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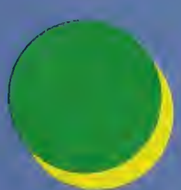

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MARS OPERATIONAL TECHNIQUES

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE
MEDICAL SERVICES ADMINISTRATION
MANAGEMENT SYSTEMS DIVISION

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The "MARS Operational Techniques" was written to assist State Medicaid personnel to review, analyze and interpret reports generated by the Management and Administrative Reporting Subsystem(MARS) of the Medicaid Management Information Systems(MMIS). These reports are designed to help in the difficult task of effectively planning, directing and controlling Medicaid programs by providing information to support the decision-making process.

This volume provides instructions in highlighting these MARS reports to determine if any program deficiences exist and then to decide what corrective action steps might be taken to correct the deficiences. The reports are divided among four functional areas of Medicaid program activity: Administration, Operations, Provider Relations and Recipient Relations

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Richard O. Godmere — February 1, 1973

Director

Management Systems Division

MARS OPERATIONAL TECHNIQUES

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1. INTRODUCTION

1. INTRODUCTION

1.1 PURPOSE

The Management and Administrative Reporting Subsystem (MARS) of the Medicaid Management Information System is intended to provide to State Title XIX Program management timely and meaningful information, reflecting the key areas of program activity. The twenty-six MARS reports are designed to help in the difficult task of effectively planning, directing and controlling a State Medicaid Program by providing information to support the decision-making process. These reports should assist program management positively to plan program activity and to avoid undesirable situations rather than being forced to react to situations as they arise.

The MARS reports, of course, are not useful in themselves; they must be interpreted and appropriately used by managers and program specialists. Therefore, this publication, the MARS Operational Techniques, develops a methodology to accomplish these tasks. Its purpose is to assist State Title XIX personnel to analyze and interpret the MARS reports; to highlight them, determine if any deficiencies exist in their program and then to decide what corrective action steps to take to correct the deficiencies. This volume is not a program regulation or a program regulation guideline and does not have

the force of such documents. Instead it is an operational technique to be used at the discretion of the State Agency to better understand and use the MARS reports. It is a form of technical assistance to those States that will be generating MARS reports as a result of implementing the MMIS, and as such, can be a point of departure for review and analysis of information and corrective action by management. While it is addressed specifically to MARS reports the material has relevance to the use of reports generated by any Medicaid information system.

There are no reports in this volume addressed specifically to Early and Periodic Screening, Diagnosis, and Treatment. This new service is currently being evaluated for integration into the MMIS and future publications will detail this integration.

The MARS Operational Techniques is designed to maximize the usefulness and effectiveness of the MARS reports resulting in:

1) Increased capability to make appropriate short range adjustments in the program while providing recipients with appropriate care and promoting sound relationships with providers to assure sufficient participation;

2) Increased capability to identify problems associated with the claims payment process and to choose the courses of action requisite for improvement;

3) Increased capabilities required in the review and development of State medical assistance policy and regulations.

1.2 Organization

1.2.1 Program Functional Areas

Chapter 3, MARS Report Presentations, comprises the major portion of this publication, both in terms of volume and importance. This chapter details, report by report, suggested operational techniques to use in order to make full use of the twenty-six MARS reports. The reports are divided among four functional areas of Medicaid program activity:

- Administration
- Operations
- Provider Relations
- Recipient Relations

Specific MARS reports have been designed to provide useful information to the individuals responsible for the performance of the duties common to each of these functional areas. Consequently each MARS report can be classified according to report content and purpose as belonging to a particular functional area.

The MARS reports in the Administration area deal with overall Program status and performance, expenditure rates, budget control, and financial planning management. In the Operations area MARS examines claim thruput performance, sources of provider payment

delay, claim filing problems, and claim error rate experience. Provider Relations encompasses all Agency interface with Title XIX providers and MARS reports on provider participation rates, provider claim filing delays, institutional cost settlement experience, and third party collection performance. In the Recipient Relations area MARS provides analyses of recipient participation rates, expenditure rates, and medical service usage experience.

1.2.2 Levels of Reporting

In addition to these functional areas, the reports may be categorized by Reporting Level, based on the amount and kind of detail they contain:

Level One (Highest) - Status Reports:
Concise summarization data which provides management with a composite overview of the current status of the Medicaid Program. There are only two reports in this level: MR-0-01, Medical Assistance Financial Status and MR-0-02, Medical Assistance Program Status.

Level Two - Summary Reports:
Consolidated management information which expands upon and directly supports Level One Reports and facilitates the planning and evaluation of existing operations within each functional area.

Level Three - Analysis Reports:

Provides more detailed information than, and is supportive of, Level Two Reports. This information permits an in-depth review and analysis of a functional area in order to identify problem areas that might be present. These reports are in the same level as the S/UR Profile Reports, and except for the Cost Settlement Details and the Provider Claims Filing Details, these MARS reports all have the word "analysis" in their titles.

Level Four (Lowest) - Detail Reports:

The lowest level of information which contains the specific detailed information from claims generated for use by given functional area. In short, they are detail listings. Most are generated within the the other subsystems and with two exceptions, Cost Settlement Details and 1099 MED, are not included in MARS reports in this volume.

1.3 Supporting Chapters

The other chapters in this volume present additional material pertaining generally to all MARS reports; as such, they may be considered supplementary to, and supportive of, Chapter 3 which addresses itself to each report on an individual basis. Topics covered in these other chapters include the role of MARS in Title XIX management and several miscellaneous considerations in the use of MARS reports. These chapters, like

Chapter 3, present information that, we trust, will be most valuable in making the maximum use of the MARS reports.

1.4 Relationship to Other Sources of Information

The MARS reports should not be considered the totality of information available to the Title XIX agency; they should not be reviewed and acted upon in a vacuum. There is much supporting and complementary data available elsewhere, within and outside of the Medicaid agency, that should be taken into consideration when deciding on what action steps to take. In the MMIS General Systems Design, Surveillance and Utilization Review (S/UR) Reports on the summary level are incorporated into MARS on the third level of management reporting. These two types of reports, S/UR and MARS, together with their respective volumes of operational techniques, should be used in conjunction with one another for short and long range planning and evaluation of program effectiveness.

The S/UR Operational Techniques is designed to assist personnel in State Medicaid agencies charged with utilization review responsibilities. It describes the use of a retrospective, exception report-based surveillance and utilization review technique. Emphasis is on making effective use of the reports generated by the S/UR subsystem of the MMIS.

Other data that should be considered when reviewing reports includes that available from provider groups and medical societies; economic indicators such as the inflation rate and the consumer price index, and the experience of the general population in obtaining medical care in terms of cost.

2. ROLE OF MARS IN TITLE XIX MANAGEMENT

2. ROLE OF MARS IN TITLE XIX MANAGEMENT

The overall objective of the Management and Administrative Reporting Subsystem (MARS) is to improve the capability of a State Agency to manage and administer its Title XIX Program. MARS is designed to provide that information which is necessary to support sound decision-making by State Agency management. Particular attention has been focused upon making available the data which is needed at each level in the State Agency organization to efficiently carry out the respective duties and responsibilities associated with that level.

MARS represents no panacea of information, but rather provides a method for consolidating and presenting in a usable form the type of information needed for effective planning and control. The MARS design features comparisons between current and past performance data, focuses attention on problem areas, and alerts managers to any undesirable trends in Program activity. The hierarchical structure of MARS reporting helps to insure efficient use of a manager's time in that he will be working with only that data which is necessary for him to properly discharge his responsibilities.

State Agency top management is presented with an overview, each month, of Program activity that includes indices selected because of their value in measuring the relative performance in each major area of Program operations. The availability of select key information will assure executive management of knowledge of any major problem arising or any dramatic shift in Program activity. Subordinate levels of management are furnished data in greater detail that will aid in defining the exact nature of a problem and assist in identifying the underlying

cause of the problem.

2.1 MARS SUPPORT OF PROGRAM PLANNING AND EVALUATION

If a State Agency is to develop effective plans for improving Medicaid Program operations in the future, State Agency management must have a clear understanding of what has transpired in the past, including knowledge of any significant trends that are at work. To assist Medicaid management in evaluating the progress of their Medicaid Program, MARS presents not only data describing the activity during the previous month, but furnishes comparable data from the same month one year ago. To provide a further basis for comparison and evaluation, the average value of certain data items is calculated and shown for the most recent six-month period. Comparisons of these historic data with current operating data will help management to determine the magnitude of shifts in Program activity and to isolate the effect of any cyclical pattern that might be present.

In each area of MARS reporting, data items have been carefully selected for their ability to accurately picture the current level of Program activity in that area. Program managers can use this information as a criteria in evaluating overall Program status or in assessing progress to-date in a given area. Availability of such performance data provides management with the capability to set realistic operational objectives and subsequently measure actual progress toward attainment of these objectives.

To assist managers in planning for the future needs of their

Medicaid Program, MARS provides not only data describing past performance, but uses such historical information to compute trends in the data and to formulate projections of future performance. Trends are calculated for key data items in each area of Program activity to provide a means of detecting significant shifts in operational performance and to form a valid basis on which to project future requirements. The trend value for a given item of data represents the average rate at which the magnitude of that data has been changing over time. To support this concept, key Program information is retained within the MARS system for a twelve-month period. The principal uses of trend computations are found in the reporting of expenditure rates for individual categories of service, provider payments, unit of service usage rates, provider participation rates, and recipient participation rates. For a more detailed explanation of how the trend is computed, see Appendix - Section 5.2.

2.2 AREAS OF CONCERN IN TITLE XIX MANAGEMENT

Preparatory to development of the MMIS, an effort was made to identify problems or areas of concern that are typically present in a State Medicaid Program. The MMIS Management and Administrative Reporting System that was subsequently developed attempts to provide, within the confines of available input, appropriate information that Medicaid management can use in responding to the needs of the Program. The various areas of concern associated with a Medicaid Program and the information made available through MARS in these areas are presented below.

BUDGET CONTROL

- Requirement - to constantly monitor Program expenditures with respect to the annual Title XIX budget.

- MARS Approach - to produce each month a budget analysis for each category of service that includes:
  (1) comparison of actual expenditures to budgeted funds.
  (2) projection of fiscal year-end expenditure totals.
  (3) calculation of projected budget variances.

FINANCIAL PLANNING

- Requirement - to have a basis for making sound estimates of future financial requirements that will satisfy the anticipated growth in the Program.

- MARS Approach - to present for each category of service and each category of aid:
  (1) current provider payment amounts
  (2) average cost per eligible recipient
  (3) historical trend of both payments and average costs to provide the means for making a realistic projection of Program funds needed for the coming year.

OUTSTANDING FINANCIAL LIABILITY

- Requirement - to have reasonable knowledge at any time of the extent of outstanding financial liability against the Program.

- MARS Approach - to provide an estimate of the value of claims in-process within the system at month's end and to provide an estimate of any additional liabilities that can be expected to result from provider cost settlement activity.

MEDICARE BUY-IN EXPERIENCE

- Requirement - to be cognizant of the level of Medicaid expenditures on behalf of Title XIX recipients who also have coverage under Title XVIII.

- MARS Approach - to describe the extent of the financial interface between Title XIX and Title XVIII including:
  (1) number of Title XIX eligibles bought-in for Part B Medicare
  (2) number of eligibles not yet accreted with SSA
  (3) cost of Medicare Part B premiums paid by Medicaid

(4) Medicaid payments for Medicare claim deductibles and coinsurance.

THIRD PARTY COLLECTIONS

- Requirement - to insure proper provider diligence in the detection and collection of third party payments for Medicaid recipients.

- MARS Approach - to rank providers within their category of service as to the percentage of their claims containing third party payments, thereby highlighting providers whose practice should be exhibiting a higher instance of third party collections.

FEDERAL REPORTING REQUIREMENTS

- Requirement - to compile the various statistics necessary to satisfy SRS report requirements for Title XIX.

- MARS Approach - to produce the SRS-NCSS 2082 report series and to furnish the necessary dollar counts, service unit counts, and unduplicated recipient counts called for in the SRS-NCSS 2078.12 & .13 and SRS-OA 25 & 41.

PROGRAM EXPENDITURES - CATEGORY OF SERVICE

- Requirement - to have knowledge of the disposition of Medicaid Program expenditures among the various services covered under the State Plan.

- MARS Approach - to provide comprehensive expenditure

statistics for each category of service including both current and prior period figures with the corresponding trend for payments received by the provider group and average payment per provider.

PROGRAM EXPENDITURES - AID CATEGORY

- Requirement - to have knowledge of the disposition of Medicaid Program expenditures among the various aid categories of Title XIX recipients.

- MARS Approach - to provide a breakout of expenditures for each aid category showing both current and prior period figures with the corresponding trend for the payments made on behalf of each recipient classification and the average payment per eligible recipient.

PROGRAM EXPENDITURES - GEOGRAPHICAL LOCATION

- Requirement - to have knowledge of the disposition of Medicaid Program expenditures among the geographical or political divisions of the state.

- MARS Approach - to provide a breakout of the number and amount of claims paid on behalf of the recipient population in each county within the state.

PROGRAM EXPENDITURES - INDIVIDUAL PROVIDERS

- Requirement - to have knowledge of which individual providers are most active in providing services under the Medicaid Program.

- MARS Approach - to furnish a listing showing all providers within a category of service ranked in order of magnitude of Medicaid payments received.

CHANGES IN MEDICAL CARE COSTS

- Requirement - to be cognizant of the extent to which the cost of medical care under the State Medicaid Program has changed over time.

- MARS Approach - to present Program expenditure rates in terms of the cost per service unit and the cost per eligible recipient, including a comparison of these rates with last year and a computation of the trend represented by these rates.

RECIPIENT POPULATION PARTICIPATION

- Requirement - to be aware of the extent to which the eligible recipient population takes advantage of the benefits available thru the Medicaid Program.

- MARS Approach - to compute for each aid category the percentage of eligible recipients actually receiving services and to facilitate a comparison of the current percentages with those of past time periods.

ACCESSIBILITY TO MEDICAL CARE

- Requirement - to detect any significant change occurring in the availability and accessibility of medical care to the recipient population.

- MARS Approach - to compute the ratio of eligible recipients to participating providers for the current period and, for comparison purposes, prior time periods.

PROVIDER POPULATION PARTICIPATION

- Requirement - to be aware of the extent to which providers enrolled in the Program are actually providing services.

- MARS Approach - to compute the percentage of enrolled providers actually participating in the Program and to provide a count of the total number of Title XIX recipients served, including comparative values for prior time periods.

GENERAL PROGRAM UTILIZATION

- Requirement - to possess knowledge of the extent to which the various Medicaid services are being utilized.

- MARS Approach - to furnish comprehensive statistics, including six-month averages and trends, describing the degree of usage in each category of service by each segment of the recipient population.

DRUG PROGRAM UTILIZATION

- Requirement - to have a detailed knowledge of which drugs are being utilized and by whom.

- MARS Approach - to rank drugs within therapeutic classification with respect to both prescribing frequency and total cost to the Program for each aid category.

CLAIM PROCESSING PERFORMANCE

- Requirement - to monitor and improve the overall performance of the claims processing operation.

- MARS Approach - to present a comprehensive set of statistics describing claim disposition, thruput efficiency, error rate experience, and error correction success.

CLAIM FILING PERFORMANCE

- Requirement - to eliminate unnecessary delays by providers in filing Medicaid claims.

- MARS Approach - to analyze claim filing patterns by category of service and subsequently identify the specific providers to whom the majority of late claim filings can be attributed.

CLAIM ERROR EXPERIENCE

- Requirement - to detect and correct excessive claim error rates whether the result of provider filing mistakes or internal processing errors.

- MARS Approach - to calculate the frequency of the claim error experience by category of service and subsequently identify the source of high error rates.

CLAIM REJECTION EXPERIENCE

- Requirement - to eliminate, in as far as possible, instances where claims must be rejected for payment.

- MARS Approach - to calculate the rate of claim rejection for each category of service and identify claim rejects which can be reduced in number through changes in processing method and provider education.

3. MARS REPORT PRESENTATIONS

3. MARS REPORT PRESENTATIONS

The MARS reports in this chapter are presented by functional area in the following order:

1) Administrative Area

Report Number	Report Name	MMIS Output #	Report Level
3.1	Medical Assistance Financial Status	MR-0-01	Level 1
3.2	Medical Assistance Program Status	MR-0-02	Level 1
3.3	Financial Summary	MR-0-03	Level 2
3.4	Expenditure Analysis	MR-0-04	Level 3
3.5	Medicare Participation Analysis	MR-0-05	Level 3
3.6	SRS-NCSS-2082	MR-0-07	Level 3

2) Operations

Report Number	Report Name	MMIS Output #	Report Level
3.7	Operational Performance Summary	MR-0-08	Level 2
3.8	Claims Processing Performance Analysis	MR-0-09	Level 3
3.9	Claims Processing Thruput Analysis	MR-0-10	Level 3
3.10	Error Distribution Analysis	MR-0-11	Level 3
3.11	Error Frequency Analysis	MR-0-18	Level 3

3) Provider Relations Area

Report Number	Report Name	MMIS Output #	Report Level
3.12	Provider Participation Summary	MR-O-06	Level 2
3.13	Provider Participation Analysis	MR-O-12	Level 3
3.14	Cost Settlement Analysis	MR-O-13	Level 3
3.15	Cost Settlement Details	MR-O-14	Level 4
3.16	Provider Claim Filing Analysis	MR-O-15	Level 3
3.17	Provider Claim Filing Details	MR-O-16	Level 3
3.18	Third Party Payment Analysis	MR-O-17	Level 3
3.19	Provider Ranking List	MR-O-19	Level 3
3.20	1099 MED	MR-O-20	Level 4
3.21	Drug Usage Analysis	MR-O-21	Level 3

4) Recipient Relations Area

Report Number	Report Name	MMIS Output #	Report Level
3.22	Recipient Participation Summary	MR-O-22	Level 2
3.23	County Participation Analysis	MR-O-23	Level 3
3.24	County Expenditure Analysis	MR-O-24	Level 3
3.25	Benefit Usage Analysis	MR-O-25	Level 3
3.26	Drug Usage by Eligibility Classification	MR-O-26	Level 3

In presenting the operational techniques for reviewing, analyzing and acting upon the twenty-six MARS reports, the following outline has been used for each report:

3.X REPORT TITLE

3.X.1 REPORT CHARACTERISTICS

MMIS Output Number: This is the number assigned to the report in the General Systems Design and may be different from the Report Number assigned in this publication where the reports are presented in a different sequence than that of the General Systems Design.

Distribution: The functional area(s) (Administration, Operations, Provider Relations, Recipient Relations) for which the report is primarily intended. The distributions, however, are merely suggestions, as each State should decide for itself who receives what report depending on its organizational and staffing requirements.

Frequency: The MARS subsystem modules will be processed monthly since no report is anticipated more frequently than monthly. There are monthly, semi-annual, annual and "as required"

reports produced by this subsystem; however, these will be produced on the coinciding monthly cycle.

Glossary Terms: Those terms found in the report and/or discussion of the report which are defined in the glossary in the Appendix.

Relation to Other MARS Reports

Other MARS reports that contain data, supporting or summary, on the same or related subject.

3.X.2 REPORT PURPOSE

The primary and secondary purposes for which the report is intended.

3.X.3 REPORT ORGANIZATION

General

A narrative description of the content and format of the report.

Sequence Information in the MARS reports is presented in three primary sequences: Category of Service, Aid Category, and Time Period. ~~Order.~~ Information on some reports may be displayed in two or more of these sequences. Many of the sample reports presented in this volume include a sequencing of information by time periods. The objective

was to display fiscal and statistical information by pertinent time periods in order that a frame of reference be established to enable evaluation of current time period data. This will aid administrators in determining program progress with respect to past performance as well as to projected future performance.

Exclusions and Limitations

This section, if applicable, may make suggestions for exception reporting: such as excluding certain data from a report in order to make the report more concise, more readable or more meaningful. For example, it is suggested that, for the Error Frequency Analysis Report, those providers with low volumes of claims not be included in the report. This section also explains any limitations a report may have such as: the Performance Analysis lists no data pertaining to resubmitted claims, which are considered as new claims.

Other Considerations

Suggestions for other optional modifications to enhance usefulness of a report.

3.X.4 REVIEW PROCEDURES

General

This section suggests procedures to use as operational techniques in reviewing and highlighting each report, focusing on certain key items. These are merely suggestions

and should not be considered definitive approaches but rather points of departure for a more detailed review and analysis. Before reviewing a report, a manager should orient himself to the content and format of the report and its relationship to other reports. Determine the extent of change in the data by comparison with previous months' reports as well as noting changes from one time period to another as listed on the report. Develop, where feasible, critical levels against which certain key data items such as averages, ratios, trends and variances, may be compared; critical levels which, if exceeded, should prompt a manager to take corrective action. Also, refer to lower level reports for possible explanations for variances found in higher level reports.

Suggested Action

Action steps to take are discussed when an analysis and interpretation of a report indicate that one or more key data items is increasing at an alarming rate, or levels are exceeding previously determined critical points. The action steps presented as operational techniques in this volume are intended for use by the appropriate State staff in order to maximize the usefulness of MARS reports. These action steps, it should be emphasized, are by no means exhaustive; indeed, staff of a State will probably arrive at many additional and varied action steps, given the particular circumstances and realities of that agency. Some reports may be considered "for information only" and, as

such, require no action.

3.X.5 SAMPLE REPORT

A sample report follows each discussion of that report in this chapter. An attempt has been made to use logical and reasonable data to facilitate their use as examples. Note that some of the reports have been changed from the General Systems Design in an attempt to improve upon them in format and/or content. Moreover, each State adopting the MMIS, will probably make further modifications depending on its needs.

3.X.6 REPORT ITEM DESCRIPTIONS

Descriptions follow each MARS sample report to provide a definition of each report item listed on the preceding report, by number. These numbers are a cross reference to the numbers on the sample report format that are enclosed in an ellipse. These cross reference numbers were developed by using the report sequence number and then a report item sequence number within each report. Report item number 8.01, then, refers to the first item on report MR-O-8.

On the next page, before the presentation of the MARS reports, is a matrix that should help the reader identify which reports contain data on certain important areas of concern in Medicaid.

MARS MATRIX BY SELECTED MEDICAID SUBJECT

AREAS OF CONCERN	ADMINISTRATION						OPERATIONS					PROVIDER RELATIONS										RECIPIENT RELATIONS					
	MR-O-01	MR-O-02	MR-O-03	MR-O-04	MR-O-05	MR-O-07	MR-O-08	MR-O-09	MR-O-10	MR-O-11	MR-O-18	MR-O-06	MR-O-12	MR-O-13	MR-O-14	MR-O-15	MR-O-16	MR-O-17	MR-O-19	MR-O-20	MR-O-21	MR-O-22	MR-O-23	MR-O-24	MR-O-25	MR-O-26	
1. Budget Control	X		X											X													
2. Financial Planning	X		X	X										X													
3. Outstanding Financial Liability		X	X				X	X								X											
4. Medicare Buy-In Experience					X																						
5. Third Party Collections																		X									
6. Federal Reporting Requirements						X														X							
7. Program Expenditures - Category of Service				X									X														
8. Program Expenditures - Aid Category				X																		X					
9. Program Expenditures - Geographical Location																								X			
10. Program Expenditures - Individual Providers															X				X								
11. Changes in Medical Care Costs	X												X														
12. Recipient Population Participation		X																				X	X				
13. Accessibility to Medical Care												X															
14. Provider Population Participation		X										X	X										X				
15. General Program Utilization				X									X											X	X		
16. Drug Program Utilization																					X					X	
17. Claim Processing Performance		X					X	X	X	X																	
18. Claim Filing Performance							X									X	X										
19. Claim Error Experience							X			X	X																
20. Claim Rejection Experience		X					X			X	X																

ADMINISTRATIVE AREA

Report Number	Report Name	MMIS Output #	Report Level
3.1	Medical Assistance Financial Status	MR-O-Ø1	Level 1
3.2	Medical Assitance Program Status	MR-O-Ø2	Level 1
3.3	Financial Summary	MR-O-Ø3	Level 2
3.4	Expenditure Analysis	MR-O-Ø4	Level 3
3.5	Medicare Participation Analysis	MR-O-Ø5	Level 3
3.6	SRS-NCSS-2082	MR-O-Ø7	Level 3

3.1 MEDICAL ASSISTANCE FINANCIAL STATUS

3.1.1 REPORT CHARACTERISTICS

MMIS Output Number:	MR-O-01
Distribution:	Administration (Executive Management)
Frequency:	Monthly
Glossary Terms:	Budget Amount
	Category of Service

Relationship to Other MARS Reports

As this report is very similar to Financial Summary (MR-O-03), a State may choose to produce only one of these reports, distributing it to the highest level of program management as well as to other appropriate personnel. This report and M.A. Program Status report (MR-O-02) are the only reports intended specifically for top management; together they provide a concise overview of Medicaid Program activities. Many other MARS reports provide supportive detail for these reports.

3.1.2 REPORT PURPOSE

General

The Medical Assistance Financial Status report is a management summary report designed to provide the highest level of program management with a concise summary of the program's financial status. The report provides a frame of reference in evaluating expenditure and budget data and as such is a useful management tool in monitoring expenditures. These reports, printed each month, will

yield a wealth of cumulative historical data, indicating seasonal and cyclical variations, that will be most useful in future budgeting.

3.1.3 REPORT ORGANIZATION

General

This report presents, by category of service, the amounts budgeted and the amounts actually expended for different time periods: The current month, same month last year, six-month average this year, and fiscal year-to-date for this and last year. Also, the report shows the amount budgeted for the entire current fiscal year as compared to a fiscal year-end projected cost. The last columns of the report show the variance (over or under) in dollars and percent between the fiscal-year-end budgeted amount and the projected cost.

Sequence	Category of Service

3.1.4 REVIEW PROCEDURES

General

For each category of service, compare this month's budget amount (report item 1.01) with the actual expenditure (report item 1.02). Then compare this month's actual expenditure (report item 1.02) with the cost figures for the same month last year (report item 1.03) and the six-month average this year (report item 1.04) to gauge the increase or decrease in cost. Next the fiscal year-to-date items: contrast and compare the actual cost (report item 1.06) with the budget amount (report item 1.05)

and the cost for the corresponding month last year (report item 1.07) to see if there is an upward or downward trend or if this month's change is due to seasonal or other temporary factors. The last four items (1.08, 1.09, 1.10, 1.11) on this report are of particular importance as they show the difference (over or under) between the fiscal year-end budget and projected cost. Using previous months' reports, determine if variance is increasing or decreasing at an accelerating rate. A useful visual aid is to have these monthly variances plotted on a graph (see Chapter 4.4). Keep in mind that a variance in one category of service may be related, directly or inversely, to a variance in another service; for example, an increase in out-patient services may be explained by a decrease in inpatient hospitalization; or a decrease in nursing home services may be the result of an increased emphasis on home health care.

Totals for all categories of service will appear at the bottom of this report; review these for summary of your program's costs.

Suggested Action

- As with the Program Status (MR-0-02), detection of change in an adverse direction, if not readily explained by program policy changes, seasonal or cyclical reasons, or other known factors, should initiate a request to the appropriate staff member for an explanation. More detailed reports are available to the second level

of management and should have prompted those managers to begin to look into the matter and take corrective action, if indicated.

- One indication that action is needed is if expenditures are increasing at an accelerating rate. Then an additional appropriation might be necessary or steps taken to reverse the trend. Some possible steps may take the form of the following administrative controls in order to contain expenditures. They are listed somewhat in order from least to most severe:

  a. Prior Authorization. This control may be used to determine in advance that certain medical services are needed, and that less expensive alternatives have been given consideration. If the need is demonstrated, then the services and cost are approved prior to the service being provided. To quote section 5-30-20 of the Medical Assistance Manual, prior authorization's "purpose is not to meet fiscal emergencies by denying or postponing needed services, although some savings should emerge as a by-product of a well - operated system."

  b. Pre-Certification (Prospective Utilization Review). Recently variations of this type of control have been applied to inpatient hospital admissions in a number

of States. At the time of admission, either for emergency or other medical services, the stay is certified for a specified length of time, perhaps the 50th percentile length of stay for persons with the same disgnosis and demographic characteristics. Should additional time be medically indicated it may be authorized. The impact of this procedure is to focus attention on discharge planning at the time of admission rather then when the patient has recovered. Initial experience in some States has resulted in reductions in hospital expenditures of about 20 percent.

c. Surveillance and Utilization Review. Adoption of the S/UR Subsystem of the MMIS and its corresponding user's manual, S/UR Operational Techniques offers sophisticated surveillance and utilization review techniques in order to detect recipients whose utilization rate is exceptional and providers whose patterns of practice are atypical. S/UR depends on routine exception report data, substantiated by professional judgment and field investigations. S/UR can be a most effective administrative control for containing expenditures.

d. Medical Review. Medical Review of patients in skilled nursing homes and intermediate care facilities is a requirement. Skillful implementation should assure that patients requiring institutionalization, but not requiring skilled nursing care will be cared for in generally less expensive intermediate care facilities. This requirement applies also to aged individuals in institutions for mental diseases. The impact should be to encourage placement in less expensive facilities whenever indicated.

e. Drug Formulary. One method of controlling expenditures of a drug program is to promulgate a drug formulary specifically detailing what drugs are covered and their allowable charges.

f. Correct Deficiencies in Claims Processing. Institute and/or improve edits for the following: recipient eligibility status, provider enrollment status, service coverage, allowable charges, third party liability, duplicate claims and payments, and time limitation claims submission.

g. Reduction in Number of Eligibles. Make more stringent the eligibility requirements for the medically needy.

h. Reduction in Fees. Except for inpatient hospital care, Federal policy sets a ceiling but no floor on the amounts that may be paid for services to providers. In reducing rates of payment, the State needs to be aware of its obligation to assure that the rate of participation of practitioners and facilities is sufficient so that the services included in the plan in fact are available to the eligibles.

i. Reduction in Services. Though a State may not eliminate the mandatory services, it may reduce them in amount and duration. Optional services may be eliminated or reduced.

- If costs are decreasing, lower utilization might be the reason. Refer to the Program Status (MR-0-02) and Recipient Participation Summary (MR-0-22) and various S/UR reports for possible root causes to insure that recipients' access to needed medical care is not being impeded.

- Use these monthly reports as bases for planning future years' budgets. They should be especially beneficial in planning for future seasonal and cyclical variations when at least two years' reports have been accumulated.

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MEDICAL ASSISTANCE FINANCIAL STATUS

CATEGORY OF SERVICE	*****THIS MONTH***** BUDGET	ACTUAL	SAME MONTH LAST YEAR	SIX MONTH AVG. THIS YEAR	*******FISCAL YEAR-TO-DATE******** BUDGET	ACTUAL	SAME MONTH LAST YEAR	****FISCAL YEAR END*** BUDGET	PROJECTED COST	******VARIANCE******* (OVER)/UNDER DOLLARS	PERCENT
INPATIENT SERVICES	1,380,000	1,387,237	1,228,979	1,568,237	11,316,000	13,996,693	13,256,110	17,250,000	19,412,996	(2,162,996)	(13%)
OUTPATIENT SERVICES	245,000	243,287	157,423	185,131	2,009,000	1,678,202	1,598,422	3,062,500	2,305,044	757,456	25%
NURSING HOME SERVICES	1,170,000	1,166,871	1,206,447	1,198,621	9,594,000	9,628,143	9,008,216	14,625,000	14,420,769	204,231	1%
PHYSICIAN SERVICES	840,000	845,623	776,000	874,187	6,888,000	7,387,160	6,845,579	10,500,000	10,263,017	236,983	2%
X-RAY AND LAB	1,000	929	462	1,249	8,200	12,891	12,896	12,500	16,558	(4,058)	(32%)
DRUGS	800,000	805,312	775,298	801,309	6,560,000	6,366,943	6,144,093	10,000,000	9,648,080	351,920	4%
DENTAL	80,000	110,863	94,600	132,961	656,000	1,123,042	894,631	1,000,000	1,615,222	(615,222)	(62%)
TOTALS	4,516,000	4,560,127	4,239,209	930,723	37,031,200	40,193,074	36,865,316	56,450,000	57,681,686	(1,231,686)	(2%)
	(1.01)	(1.02)	(1.03)	(1.04)	(1.05)	(1.06)	(1.07)	(1.08)	(1.09)	(1.10)	(1.11)

3.1.6 REPORT ITEM DESCRIPTION

MEDICAL ASSISTANCE FINANCIAL STATUS

Item Number	Item Name and Description
1.01	EXPENDITURE THIS MONTH - The Medicaid payment for the most recent month covered by the report.
1.02	BUDGET THIS MONTH - The amount budgeted for expenditure in the most recent month covered by the report.
1.03	SAME MONTH LAST YEAR - The Medicaid payment for the corresponding month in the previous fiscal year.
1.04	SIX MONTH AVERAGE THIS YEAR - The average monthly Medicaid payment for the most recent six months covered by the report.
1.05	FISCAL YEAR TO DATE BUDGETED AMOUNT - The total of the monthly amounts budgeted for expenditure in the time period from the beginning of the fiscal year through the most recent month covered by the report.
1.06	FISCAL YEAR TO DATE EXPENDITURE AMOUNT - The total Medicaid payments in the time period from the beginning of the fiscal year through the most recent month covered by the report.
1.07	FISCAL YEAR TO DATE, SAME MONTH LAST YEAR - The total Medicaid payments in the time period from the beginning of the previous fiscal year through the month in the previous fiscal year that corresponds to the most recent month covered by the report.

Item Number	Item Name and Description
1.08	FISCAL YEAR BUDGET AMOUNT - The total amount budgeted for expenditure in the current fiscal year.
1.09	FISCAL YEAR PROJECTED COST - The total projected expenditure for the fiscal year. This projection is based on actual expenditures for the most recent twelve months using the least squares method.
1.10	VARIANCE DOLLARS - The dollar difference between the budgeted amount for the fiscal year and the projected total fiscal year expenditure. Projected costs in excess of their budgeted amount are shown in parentheses.
1.11	VARIANCE PERCENT - The variance amount as a percentage of the fiscal year budget amount, (1.10 ÷ 1.08). If the projected costs exceed the budget, the variance percentage is enclosed in parentheses.

3.2 MEDICAL ASSISTANCE PROGRAM STATUS

3.2.1 REPORT CHARACTERISTICS

MMIS Output Number: MR-O-02

Distribution: Administration (Executive Management)

Frequency: Monthly

Glossary Terms: Approved, Rejected, Recipient, Service Unit

Relationship to Other MARS Reports

The Medical Assistance Program Status report combines with the Medical Assistance Financial Status (MR-O-Ø1) to furnish the highest level of Medicaid Program management with an overview of total Program activity. The Program Status is directly supported by the Provider Participation Summary (MR-O-Ø6), the Operational Performance Summary (MR-O-Ø8), and the Recipient Participation Summary (MR-O-22). Numerous other MARS reports indirectly contribute to the Program Status by providing additional detail that supports these three summary reports.

3.2.2 REPORT PURPOSE

The Medical Assistance Program Status report is designed to provide executive Program management with concise pertinent data that describes the current status of Medicaid Program activity in three major Program areas - recipient eligibility, provider enrollment, and claims processing. Information from previous time periods is shown in addition to data for the most recent month in order to provide a frame of reference for measuring Program progress. Through this report management has ready access to critical information about the status of the Program and can ensure that agency activities are proceeding in the direction planned.

3.2.3 REPORT ORGANIZATION

The Medical Assistance Program Status report presents key information items concerning three important areas of the Medicaid Program. This one page report contains information on recipient eligibility, provider enrollment, and claims processing for five different time periods - current month, current month last year, most recent six month average, and this year and last year fiscal year to date.

3.2.4 REVIEW PROCEDURES

General

The Medical Assistance Program Status report should be reviewed by the highest administrative executive in the Title XIX Program. Analysis should begin with a comparison of each of the entries in the current report month column to the entries in the columns reflecting results in previous periods. The detection of any significant change in an adverse direction, if not readily explainable by revised Program policy, seasonable factors, or other reasons, should initiate a request to the responsible department for an explanation. Normally other more detailed MARS reports, directed to the second level of management, will have already prompted those managers to undertake investigation and institute appropriate corrective action.

Suggested Action

- The percent of enrolled recipients receiving service (report item 2.03) is a rough indicator of:
  a. The awareness on the part of recipients of Program benefits available.
  b. The extent to which recipients have access to medical services.
  c. The need that recipients have for medical services.

Significant changes in this percentage should be investigated further by analysis of the Recipient Participation Summary (MR-O-22).

- Medicaid Program budget planning can be facilitated through use of the average cost per participating recipient figure (report item 2.04) to project the additional costs to the Program that would result from increases in recipient participation.
- A marked decrease in the percent of providers participating is indicative of growing dissatisfaction on the part of providers with the Medicaid Program and should be reason for immediate concern. The Provider Participation Summary (MR-O-Ø6) and Provider Participation Analysis (MR-O-12) should help to isolate the cause of the drop-off in provider participation.
- The appearance of a relatively large percent of claims rejected (report item 2.14) in comparison with prior periods might be indicative of problems arising out of the claims processing operation. The Operational Performance Summary (MR-O-Ø8) and the various MARS operations reports that support it should be consulted to determine the existence and nature of any suspected claims processing problem.
- Program management should be sensitive to any major increases in the average days that elapse from claim receipt by the Agency until claim approval for payment (report item 2.15). This indicator is a measure of the overall performance of the claims processing department. Increases in the average time required to process a claim should be investigated by examining the Claims Processing Thruput Analysis (MR-O-1Ø).

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M E D I C A L A S S I S T A N C E P R O G R A M S T A T U S

		THIS MONTH	SAME MONTH LAST YEAR	SIX MONTH AVG. THIS YEAR	*** FISCAL YEAR-TO-DATE *** THIS YEAR	LAST YEAR
RECIPIENTS **********						
NUMBER OF RECIPIENTS ENROLLED	2.01	248,690	234,861	246,022	247,980	236,820
NUMBER OF RECIPIENTS RECEIVING SERVICE	2.02	104,101	97,846	101,560	227,339	218,430
PERCENT OF ENROLLED RECIPIENTS RECEIVING SERVICE	2.03	41.9 %	41.7 %	41.3 %	91.7 %	92.2 %
AVG. COST PER PARTICIPATING RECIPIENT	2.04	34.18	30.84	36.90	197.62	189.43
PROVIDERS **********						
NUMBER OF PROVIDERS ENROLLED	2.05	4,879	4,720	4,738	4,779	4,718
NUMBER OF PROVIDERS PARTICIPATING	2.06	2,730	2,432	2,489	4,262	3,901
PERCENT OF PROVIDERS PARTICIPATING	2.07	56.0 %	51.5 %	52.5 %	89.2 %	82.7 %
TOTAL SERVICE UNITS RENDERED	2.08	728,707	684,922	710,920	8,744,484	9,219,064
AVG. SERVICES PER PARTICIPATING PROVIDER	2.09	267	281	285	2,054	2,107
AVG. PAYMENT PER PARTICIPATING PROVIDER	2.10	1,228	1,241	1,506	10,541	10,607
CLAIM PROCESSING OPERATIONS **********						
TOTAL CLAIMS PROCESSED	2.11	343,940	320,428	342,890	4,127,280	3,845,136
PERCENT PAID	2.12	90.5 %	90.8 %	90.1 %	91.3 %	90.4 %
PERCENT REJECTED	2.13	5.2 %	6.1 %	5.6 %	5.8 %	5.3 %
CLAIMS IN PROCESS AT MONTH END	2.14	109,911	98,666	110,042	108,610	96,813
AVG. DAYS FROM CLAIM RECEIPT TO APPROVAL	2.15	22.7	24.3	21.9	21.2	21.3

3.2.6 REPORT ITEM DESCRIPTION

MEDICAL ASSISTANCE PROGRAM STATUS

Item Number	Item Name and Description
2.Ø1	NUMBER OF RECIPIENTS ENROLLED - An unduplicated count of the number of recipients eligible for Medicaid benefits during the time period shown.
2.Ø2	NUMBER OF RECIPIENTS RECEIVING SERVICE - An unduplicated count of the number of recipients receiving Medicaid benefits during the time period shown.
2.Ø3	PERCENT OF ENROLLED RECIPIENTS RECEIVING SERVICE - The number of recipients receiving service divided by the number of recipients enrolled (2.Ø2 ÷ 2.Ø1 x 1ØØ).
2.Ø4	AVERAGE COST PER PARTICIPATING RECIPIENT - The average Medicaid expenditure for recipients receiving Medicaid benefits.
2.Ø5	NUMBER OF PROVIDERS ENROLLED - The number of providers that have agreed to participate in the Medicaid program or, if provider agreements are not required, the number of providers that have participated in the past.
2.Ø6	NUMBER OF PROVIDERS PARTICIPATING - An unduplicated count of the number of providers that rendered services to Medicaid recipients in the time period shown.
2.Ø7	PERCENT OF PROVIDERS PARTICIPATING - The number of providers participating as a percent of the number of providers enrolled.

Item Number	Item Name and Description
2.Ø8	TOTAL SERVICE UNITS RENDERED - The total units of service rendered by providers to Medicaid recipients.
2.Ø9	AVERAGE SERVICES PER PARTICIPATING PROVIDER - The average number of service units provided by participating providers.
2.1Ø	AVERAGE PAYMENT PER PARTICIPATING PROVIDER - The average amount paid to participating providers for services rendered.
2.11	TOTAL CLAIMS PROCESSED - The number of claims processed by the claims processing system. This count includes new claims received during the month plus prior claims recirculated through the system this month.
2.12	PERCENT APPROVED - The percentage of total claims processed approved for payment.
2.13	PERCENT REJECTED - The percent of the total claims processed that were denied or returned to the provider for correction of errors.
2.14	CLAIMS IN PROCESS AT MONTH END - The number of claims not yet adjudicated at the end of the month. The Fiscal Year to Date columns contain a monthly average.
2.15	AVERAGE DAYS FROM ENTRY DATE TO APPROVAL - The average number of days between the date the claim is received by the State Agency and the date the claim is approved for payment.

3.3 FINANCIAL SUMMARY

3.3.1 REPORT CHARACTERISTICS

MMIS Output Number: MR-O-03

Distribution: Administration
Provider Relations
Recipient Relations
Operations

Frequency: Monthly

Glossary Terms: Category of Service
Budget Amount

Relationship to Other MARS Reports

This report is almost identical to the Financial Status (MR-O-01) which is designed for top management, except that this report has several additional items: one pertaining to estimated cost settlement, another to claims in process and variances for all time periods not just year-end. A State may choose to produce only one of these reports, distributing it to the highest level of program management as well as to other appropriate personnel. Other related reports include: Expenditure Analysis (MR-O-04) and County Expenditure Analysis (MR-O-24).

3.3.2 REPORT PURPOSE

The Financial Summary is a management summary report for Level II managers. It presents a concise summary of the

program's financial status. Like the Level I Financial Status (MR-0-01), it provides a frame of reference in evaluating expenditure and budget data and is a useful tool in monitoring expenditures and evaluating the program's fiscal status. As such it is invaluable in short and long range budgetary planning.

3.3.3 REPORT ORGANIZATION

General

This report presents, by category of service, the amounts budgeted and the amounts actually expended for different time periods: the current month, same month last year, six-month average this year and fiscal year-to-date for this year and last year. Also, the report shows the amount budgeted for the entire current fiscal year as compared to a fiscal year-end projected cost as well as the variance in dollars and percent, between these two time periods. This report, unlike the Financial Status (MR-0-01) report, shows the estimated cost settlement (report item 3.05) and the dollar value of the claims in process (report item 3.06).

Sequence	Category of Service

3.3.4 REVIEW PROCEDURES

General

For each category of service, compare this month's budget amount (report item 3.01) with the actual expenditure

(report item 3.02). Then compare this month's actual expenditure (report item 3.02) with the cost figures for the same month last year and the six-month average this year to guage the increase or decrease in cost. Next the fiscal year-to-date items: contrast and compare the actual cost with the budget amount and the cost for the corresponding month last year to see if there is an upward or downward trend or if this month's change is due only to seasonal or other temporary factors. The variance items (3.03 and 3.04) are of particular importance as they show the difference, over or under, between the fiscal year-end budget and projected cost. Referring to previous months' reports, determine if the variance is increasing or decreasing at an accelerating rate. A useful visual aid is to plot these monthly variances on a graph (See Chapter 4.4). As a variance in one category of service may be related, directly or inversely, to a variance in another category of service, compare each data item from one category to another. An increase in outpatient services may perhaps be explained by a decrease in inpatient hospitalization; or a decrease in nursing home services may be the result of an increased emphasis on home health care.

Totals for all categories of service will appear at the bottom of this report; review these for a summary of the program's cost.

Suggested Action

- Detection of change in an adverse direction, if not readily explained by program policy changes, seasonal or cyclical reasons, or other readily apparent factors should prompt an investigation into the matter, and corrective action should be taken, if indicated. Top management will be receiving an almost identical report, the Medical Assistance Financial Status (MR-0-01), and will probably be requesting from Level II managers an explanation of any adverse changes.

- One indication that action is needed is if expenditures are increasing at an accelerating rate. Then an additional appropriation might be necessary or steps taken to reverse the trend. (See possible administrative controls to contain expenditures listed in the discussion of the Medical Assistance Financial Status Report (MR-0-01).)

- If costs are decreasing, lower utilization might be the reason. Refer to the Recipient Participation Summary (MR-0-22) and various S/UR reports for possible root causes to insure that recipients' access to needed medical care is not being impeded.

- Use these monthly reports as bases for planning future years' budgets. They should be especially helpful in planning for seasonal and cyclical variations.

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F I N A N C I A L S U M M A R Y

CATEGORY OF SERVICE		THIS MONTH	SAME MONTH LAST YEAR	SIX MONTH AVG. THIS YEAR	FISCAL YEAR-TO-DATE THIS YEAR	FISCAL YEAR-TO-DATE LAST YEAR	PROJECTED FISCAL YEAR END
PHYSICIAN SERVICES							
BUDGET	(3.01)	840,000	835,000	868,000	6,888,000	7,175,000	10,500,000
EXPENDITURE	(3.02)	845,623	776,000	874,187	7,387,160	6,845,579	10,263,017
VARIANCE: DOLLARS (OVER)/UNDER	(3.03)	(5,623)	59,000	(6,187)	(499,160)	329,421	236,983
PERCENT	(3.04)	(.7 %)	7.0 %	(.7 %)	(7.3 %)	4.6 %	2.3 %
ESTIMATED COST SETTLEMENT (DEFICIT)	(3.05)	NOT APPLICABLE FOR THIS SERVICE					
CLAIMS IN PROCESS (DOLLARS)	(3.06)	281,874	258,666	284,362	N/A	N/A	N/A
TOTAL FOR ALL CATEGORIES OF SERVICE							
BUDGET		4,516,000	4,608,000	4,600,000	37,031,200	37,785,600	56,450,000
EXPENDITURE		4,560,127	4,239,209	4,700,000	40,193,074	36,865,316	57,681,686
VARIANCE: DOLLARS (OVER)/UNDER		(44,127)	368,796	(100,000)	(3,161,874)	920,284	(1,231,686)
PERCENT		(1.0 %)	8.0 %	(2.2 %)	(8.5 %)	2.4 %	(2.2 %)
ESTIMATED COST SETTLEMENT (DEFICIT)		(22,800)	21,196	N/A	N/A	N/A	N/A
CLAIMS IN PROCESS (DOLLARS)		1,520,042	1,413,069	1,520,302	N/A	N/A	N/A

3.3.6 REPORT ITEM DESCRIPTION

FINANCIAL SUMMARY

Item Number	Item Name and Description
3.01	BUDGET - The amount budgeted for expenditure in the time periods shown.
3.02	EXPENDITURE - The actual Medicaid payment in the time periods shown. The amount shown under "Projected Fiscal Year End" is projected from the most recent twelve month's actual expenditures using the least squares method.
3.03	VARIANCE DOLLARS - The dollar difference between the budgeted amount and the actual or projected expenditures. (3.01 - 3.02) Actual or projected costs in excess of their budgeted amounts are enclosed in parentheses.
3.04	VARIANCE PERCENT - The variance amount as a percentage of the budgeted amount. If the actual or projected expenditures exceed the budgeted amount, the variance percentage is enclosed in parentheses.
3.05	ESTIMATED COST SETTLEMENT - The difference in the interim payments to cost settled providers and the estimated total of actual provider costs. This amount should equal the total of report item 13.08 on the Cost Settlement Analysis (MR-O-13).
3.06	CLAIMS IN PROCESS (DOLLARS) - The total of all charges shown on claims in the suspense file at month end. The SIX MONTH AVERAGE THIS YEAR contains the average month end value of claims for the most recent six months.

3.4 EXPENDITURE ANALYSIS

3.4.1 REPORT CHARACTERISTICS

MMIS Output Number:	MR-O-Ø4
Distribution:	Administration Recipient Relations
Frequency:	Monthly
Glossary Terms:	Service Unit Trend

Relationship to Other MARS Reports

The Expenditure Analysis provides supporting detail to the Medical Assistance Financial Status (MR-O-Ø1) and the Financial Summary (MR-O-Ø3) reports.

3.4.2 REPORT PURPOSE

The Expenditure Analysis is designed to provide administrative management with detailed information concerning the disbursement of Medicaid funds to support financial planning and Program policy development. A trend indication accompanies each total figure to assist in identification of areas where the magnitude of change is greatest. The report is designed to show the distribution of Program expenditures among the various classifications of Program eligibles for each category of service available under the State Plan.

3.4.3 REPORT ORGANIZATION

General

The Expenditure Analysis provides a breakout for each category of service of key information items concerning expenditures for certain categories of recipient eligibility. Individual aid category (OAA, AB, etc.) data is shown for the eligibility classifications of (1) categorically needy (including both recipients receiving money payments and

those not receiving money payments) and (2) medically needy. The distinction between categorically needy and medically needy will, of course, be unnecessary in States not extending Medicaid benefits to the medically needy population.

Sequence Category of Service

Exclusions and Limitations

Medicaid payments for Medicare deductible and coinsurance claims (Medicare crossovers) for the OAA aid classification should not be included in the report as shown, but if desired, could be presented separately as an additional page to the Expenditure Analysis.

Suggested Totals and Summaries

Totals for each eligibility classification for each category of service are shown on the sample report. Grand totals for each eligibility classification with all categories of service combined are recommended.

3.4.4 REVIEW PROCEDURES

The Expenditure Analysis is designed to provide Program management with knowledge of not only where Medicaid dollars are being spent (i.e., for which category of service) but for whom these expenditures are being made. The various statistics are provided in terms of the recipient eligibility classifications specified for annual Program reporting to HEW. The availability of this Program utilization information should prove to be of value in ascertaining which individual recipient classes are responsible for expenditure increases. The trend figures are supplied principally to aid management in identifying shifting patterns in Program usage by the recipient population. The absolute amount of change in any item of information over a period of time can be determined through reference to previous month reports.

The Expenditure Analysis can also be of use in typical budget and financial planning activities in the State Agency. As an example, if certain percentage increases in recipient enrollment are anticipated in a given aid category, then use of the appropriate average payment per recipient experience figure will permit calculation of the approximate expenditures that can be anticipated to occur in each particular category of service.

MONTH OF 6/72

E X P E N D I T U R E A N A L Y S I S

CATEGORY OF SERVICE: PHYSICIAN SERVICES

	PAYMENTS TOTAL	PAYMENTS TREND	UNITS OF SERVICE RENDERED TOTAL	UNITS OF SERVICE RENDERED TREND	SERVICE UNITS PER ELIGIBLE RECIPIENTS AVERAGE	SERVICE UNITS PER ELIGIBLE RECIPIENTS TREND	AVERAGE COST PER ELIGIBLE RECIPIENT AVERAGE	AVERAGE COST PER ELIGIBLE RECIPIENT TREND
CATEGORICALLY NEEDY (MONEY PAYMENT)								
OAA	246,684	+.010	25,160	+.002	.571	+.003	5.60	+.010
AB	10,130	+.015	1,356	+.001	1.306	+.001	9.76	+.015
APTD	157,024	+.011	25,977	+.001	1.497	+.002	9.05	+.011
AFDC CHILDREN	91,175	+.010	15,056	+.001	.623	+.002	3.77	+.010
AFDC ADULTS	1,519	+.012	271	+.001	1.514	+.002	8.49	+.012
TOTAL	506,532		67,820		.781		5.84	
CATEGORICALLY NEEDY (NO MONEY PAYMENT)								
OAA	147,433	+.010	10,915	+.002	.623	+.003	73.86	+.013
AB	156	+.015	42	+.001	1.518	+.001	39.00	+.012
APTD	17,184	+.011	3,094	+.001	1.614	+.002	80.68	+.011
AFDC CHILDREN	14,993	+.010	2,676	+.001	1.738	+.002	9.74	+.010
AFDC ADULTS	132,440	+.012	23,754	+.001	1.765	+.002	9.84	+.013
OTHER XIX CHILDREN UNDER 21	154	+.015	40	+.002	.482	+.001	1.86	+.019
TOTAL	312,360		41,821		2.419		18.06	
MEDICALLY NEEDY								
OAA-RELATED	11,582	+.035	925	+.002	1.071	+.003	6.45	+.038
AB-RELATED	510	+.010	91	+.001	2.106	+.002	10.61	+.013
APTD-RELATED	811	+.042	145	+.001	2.247	+.001	9.95	+.048
AFDC-RELATED CHILDREN	6,211	+.050	1,114	+.001	1.475	+.002	4.50	+.054
AFDC-RELATED ADULTS	5,612	+.017	1,007	+.001	2.504	+.002	9.02	+.021
OTHER XIX CHILDREN UNDER 21	385	+.038	69	+.001	.950	+.001	2.58	+.041
OTHER XIX ADULTS 21-64	215	+.051	39	+.001	2.502	+.002	10.63	+.058
TOTAL	25,326		3,390		1.775		6.83	
TOTAL XIX RECIPIENTS	844,218		113,031		2.819		8.72	
OTHER RECIPIENTS								
	(4.01)	(4.02)	(4.03)		(4.04)		(4.05)	

3.4.6 REPORT ITEM DESCRIPTIONS

EXPENDITURE ANALYSIS

Item Number	Item Name and Description
4.Ø1	TOTAL PAYMENTS - The total dollar expenditure for services rendered by providers in the category of service and the aid category indicated.
4.Ø2	TREND - A measure of the rate at which the magnitude of the data is changing. See Section 5.2 for a discussion of the method used to compute the trend figure.
4.Ø3	TOTAL UNITS OF SERVICE RENDERED - The total units of service rendered by providers in the category of service indicated to Medicaid recipients in the aid category indicated.
4.Ø4	AVERAGE SERVICE UNITS PER ELIGIBLE RECIPIENT - The total units of service received in this category divided by the total number of eligible recipients.
4.Ø5	AVERAGE COST PER ELIGIBLE RECIPIENT - Total Medicaid expenditures in this category of service divided by the total number of eligible recipients.

3.5 MEDICARE PARTICIPATION ANALYSIS

3.5.1 REPORT CHARACTERISTICS

MMIS Output Number:	MR-O-Ø5
Distribution:	Administration Provider Relations
Frequency:	Monthly
Glossary Terms:	Buy-In Crossover Claims Medicaid-Medicare Eligible

Relationship to Other MARS Reports

There are no other MARS reports that present information on the Medicaid-Medicare relationship. There are, however, several reports in the MMIS Recipient Subsystem that deal with the Medicare Part B buy-in process.

3.5.2 REPORT PURPOSE

The Medicare Participation Analysis is designed to provide information about the relationship between Medicaid and Medicare for those Medicaid recipients that are eligible for both programs. Through this report, the respective expenditures of each program for Medicaid-Medicare recipients may be determined, including a breakout of costs for both Part A and Part B covered services. Control information concerning payment of claims for Medicare coinsurance and deductibles, number of recipients eligible and bought in for Part B, and the cost of the Part B premiums is presented to keep management informed about all facets of the Medicaid-Medicare interface.

3.5.3 REPORT ORGANIZATION

Basically, the Medicare Participation Analysis is a two-page summarization of information gathered from a variety of

sources and combined in such a manner as to provide a concise picture of the Medicaid-Medicare relationship. The report is divided into three major sections - Part A Medicare, Part B Medicare, and Parts A and B jointly. Report content includes primarily data on Medicare enrollment, premium payments, claims processed, and respective Medicaid and Medicare expenditures. Each report item is presented for five different time periods.

3.5.4 REVIEW PROCEDURES

General

Many aspects of the Medicaid-Medicare interface are dictated by Federal legislation, which makes the Medicare Participation Analysis more of an information report than a management report. However, even though the interaction between the programs is strictly defined, there are areas of performance that should be monitored. These areas include the accountability for Medicare crossover claims and the timely identification and maintenance of proper Medicare eligibility status within the Medicaid system.

Suggested Action

The number of recipients 65 or older that are not accreted (report item 5.Ø9) should remain fairly constant. If this figure increases significantly, it could indicate that the clerical unit responsible for the Medicare Part B buy-in process requires attention - either in the form of additional training, improved procedures, or more personnel.

RUN DATE 6/30/72

MONTH OF 6/72

MEDICARE PARTICIPATION ANALYSIS

		THIS MONTH	SAME MONTH LAST YEAR	SIX MONTH AVG THIS YEAR	**** FISCAL YEAR-TO-DATE ** THIS YEAR	LAST YEAR
TOTAL RECIPIENTS 65 OR OLDER	5.01	80,393	75,242	79,032		
PART A						
RECIPIENTS 65 OR OLDER NOT ELIGIBLE FOR PART A	5.02	42	80	28		
NUMBER CLAIMS RECEIVED	5.03	2,868	2,799	2,805	33,675	33,008
PAYMENTS PENDING	5.04	22,980	21,868	23,042		
TOTAL MEDICAID PAYMENTS FOR PART A DEDUCTIBLE AND COINSURANCE	5.05	128,505	129,450	130,960	1,443,682	1,338,493
TOTAL MEDICARE PART A PAYMENTS FOR CROSSOVER CLAIMS	5.06	414,020	375,920	401,610	4,948,622	*4,411,623
MEDICAID EXPENDITURES AS A PERCENT OF TOTAL PAYMENTS MADE FOR MEDICAID-MEDICARE ELIGIBLES	5.07	23.7 %	25.6 %	24.6 %	22.6 %	23.3 %
PART B						
RECIPIENTS BOUGHT IN	5.08	80,059	73,444	80,002		
RECIPIENTS 65 OR OLDER NOT ACCRETED	5.09	292	96	131		
TOTAL BUY-IN PREMIUM	5.10	450,200	381,908	448,011	5,376,132	4,548,380
NUMBER CLAIMS RECEIVED	5.11	23,099	22,102	23,610	23,420	22,842
PAYMENTS PENDING	5.12	49,687	62,483	54,833	596,244	580,830

MEDICARE PARTICIPATION ANALYSIS

		THIS MONTH	SAME MONTH LAST YEAR	SIX MONTH AVG THIS YEAR	*** FISCAL YEAR-TO-DATE *** THIS YEAR	LAST YEAR
PART B (CONTINUED)						
TOTAL MEDICAID PAYMENTS FOR PART B DEDUCTIBLE AND COINSURANCE	(5.13)	276,985	222,364	273,622	3,321,820	2,668,368
TOTAL MEDICARE PART B PAYMENTS FOR CROSSOVER CLAIMS	(5.14)	1,163,337	1,022,338	1,174,823	12,960,044	11,268,044
TOTAL MEDICAID PAYMENTS (BUY-IN, DEDUCTIBLES AND COINSURANCE) AS A % OF TOTAL MEDICARE AND MEDICAID PAYMENTS ON BEHALF OF MEDICAID-MEDICARE ELIGIBLES	(5.15)	38.5 %	37.1 %	38.1 %	40.2 %	39.0 %
BUY-IN PREMIUM AS A PERCENT OF MEDICARE PART B PAYMENTS	(5.16)	38.7 %	37.4 %	38.1 %	41.5 %	40.4 %
PARTS A AND B						
TOTAL MEDICAID EXPENDITURES FOR MEDICAID-MEDICARE ELIGIBLES (BUY-IN, DED., AND COINS.)	(5.17)	855,690	733,722	852,593	10,141,638	8,555,241
TOTAL PAYMENTS BY MEDICARE AND MEDICAID ON BEHALF OF MEDICAID-MEDICARE ELIGIBLES	(5.18)	2,443,047	2,131,980	2,429,026	28,050,304	24,234,908
TOTAL MEDICAID EXPENDITURES FOR MEDICAID-MEDICARE ELIGIBLES AS A PERCENT OF TOTAL PAYMENTS ON BEHALF OF MEDICAID-MEDICARE ELIGIBLES	(5.19)	35.0 %	34.4 %	35.1 %	36.2 %	35.3 %

3.5.6 REPORT ITEM DESCRIPTIONS

MEDICARE PARTICIPATION ANALYSIS

Item Number	Item Name and Description
5.Ø1	TOTAL RECIPIENTS 65 OR OLDER - A count of Medicaid recipients that have attained the age of sixty-five.
5.Ø2	RECIPIENTS 65 OR OLDER NOT ELIGIBLE FOR Part A - A count of Medicaid recipients over sixty-five that do not qualify for Medicare.
5.Ø3	NUMBER CLAIMS RECEIVED - The number of Medicare Part A claims received by Medicaid for payment of the Medicare deductible and coinsurance for those Medicaid recipients eligible for Medicare.
5.Ø4	PAYMENTS PENDING - The total amount of the deductible and coinsurance on Medicare Part A claims that have been received but not adjudicated.
5.Ø5	TOTAL MEDICAID PAYMENTS FOR PART A DEDUCTIBLE AND COINSURANCE - The total payment for Medicare Part A services made by Medicaid for Medicaid-Medicare eligibles.
5.Ø6	TOTAL MEDICARE PART A PAYMENTS FOR CROSSOVER CLAIMS - The amount paid by Medicare for Part A services rendered to Medicaid-Medicare eligibles.
5.Ø7	MEDICAID EXPENDITURES AS A PERCENT OF TOTAL PAYMENTS MADE FOR MEDICAID-MEDICARE ELIGIBLES - The percent of the expenditures by Medicaid and Medicare for Part A services to Medicaid-Medicare eligibles that Medicaid paid.

Item Number	Item Name and Description
5.Ø8	RECIPIENTS BOUGHT IN - The number of Medicaid recipients whose Medicare Part B premium is paid by Medicaid.
5.Ø9	RECIPIENTS 65 OR OLDER NOT ACCRETED - The number of Medicaid recipients that are sixty-five or older and have not been accepted as eligible for Part B coverage by Medicare.
5.1Ø	TOTAL BUY IN PREMIUM - The total premium paid by Medicaid to Medicare for recipients bought in.
5.11	NUMBER CLAIMS RECEIVED - The number of Medicare Part B claims received by Medicaid for payment of the Medicare deductible and coinsurance for those Medicaid recipients eligible for Medicare.
5.12	PAYMENTS PENDING - The total amount of the deductible and coinsurance on Medicare Part B claims that have been received but not adjudicated.
5.13	TOTAL MEDICAID PAYMENTS FOR PART B DEDUCTIBLE AND COINSURANCE - The total payment for Medicare Part B services made by Medicaid for Medicaid-Medicare eligibles.
5.14	TOTAL MEDICAID PART B PAYMENTS FOR CROSSOVER CLAIMS - The amount paid by Medicare for Part B services rendered to Medicaid-Medicare eligibles.

Item Number	Item Name and Description
5.15	TOTAL MEDICAID PAYMENTS (BUY IN, DEDUCTIBLES AND COINSURANCE) AS A PERCENT OF TOTAL MEDICARE AND MEDICAID PAYMENTS ON BEHALF OF MEDICAID-MEDICARE ELIGIBLES - The sum of items 5.1Ø and 5.13 divided by the sum of items 5.1Ø, 5.13 and 5.14 and multiplied by 1ØØ.
5.16	BUY IN PREMIUM AS A PERCENT OF MEDICARE PART B PAYMENTS - Item 5.1Ø divided by item 5.14 and multiplied by 1ØØ.
5.17	TOTAL MEDICAID EXPENDITURES FOR MEDICAID-MEDICARE ELIGIBLES (BUY IN, DEDUCTIBLE, AND COINSURANCE) - The sum of items 5.5, 5.1Ø and 5.13.
5.18	TOTAL PAYMENTS BY MEDICARE AND MEDICAID ON BEHALF OF MEDICAID-MEDICARE ELIGIBLES - The sum of items 5.5, 5.6, 5.1Ø, 5.13 and 5.14.
5.18	TOTAL MEDICAID EXPENDITURES FOR MEDICAID-MEDICARE ELIGIBLES AS A PERCENT OF TOTAL PAYMENTS ON BEHALF OF MEDICAID-MEDICARE ELIGIBLES - Item 5.17 divided by item 5.18 multiplied by 1ØØ.

3.6 SRS-NCSS-2082

3.6.1 REPORT CHARACTERISTICS

MMIS Output Number:	MR-O-07
Distribution:	Administration
Frequency:	Yearly

3.6.2 REPORT PURPOSE

This Federal report presents Medicaid expenditures and recipient counts by various statistical and demographic groupings on an annual basis.

3.6.3 REPORT ORGANIZATION

The report format and report items for this output are specified by the National Center for Social Statistics on Form OMB No. 83-RO-206. All report items can be supported by the MMIS.

OPERATIONS AREA

Report Number	Report Name	MMIS Output #	Report Level
3.7	Operational Performance Summary	MR-O-Ø8	Level 2
3.8	Claims Processing Performance Analysis	MR-O-Ø9	Level 3
3.9	Claims Processing Thruput Analysis	MR-O-1Ø	Level 3
3.10	Error Distribution Analysis	MR-O-11	Level 3
3.11	Error Frequency Analysis	MR-O-18	Level 3

3.7 OPERATIONAL PERFORMANCE SUMMARY

3.7.1 REPORT CHARACTERISTICS

MMIS Output Number:	MR-O-Ø8	
Distribution:	Operations Administration Provider Relations	
Frequency:	Monthly	
Glossary Terms:	Approved Rejected	Errors Suspended

Relationship to Other MARS Reports

The Operational Performance Summary is one of a series of MARS reports concerned with the level of performance of the claims processing operation. The salient data from each of the above reports is summarized in the Operational Performance Summary for senior management. The Claims Processing Thruput Analysis (MR-O-1Ø) measures the length of time from claim receipt by the State Agency to claim approval by the State Agency. The Claims Processing Performance Analysis (MR-O-Ø9) looks at performance of the Medicaid computer system. The Error Distribution Analysis (MR-O-11) examines the extent and nature of errors detected in the claims. The Error Frequency Analysis (MR-O-18) presents individual provider statistics concerning claim error experience.

3.7.2 REPORT PURPOSE

The Operational Performance Summary report is designed to summarize key information that reflects the current status of activities concerning the receipt, processing, and approving for payment of provider submitted claims. The report is intended for higher echelons of management in order that they may evaluate the performance of the claims processing

operations and determine if areas for improvement exist. The report, in particular, is designed to call attention to the error rate being experienced and the average times required for claim approval. Management is continually concerned with achieving a minimum error rate and a rapid turnover in the claim suspense file in order to increase processing efficiency and lower claim handling costs. Likewise a reduction in the time elapsing from rendering of the service to approval of the claim for payment will increase provider satisfaction with the Program proportionately, as well as facilitate State Agency budget planning.

3.7.3 REPORT ORGANIZATION

General

The Operational Performance Summary report presents various summary statistics depicting claim receipt, thruput experience, disposition, error rates, and error correction performance. All figures are calculated and presented by individual category of service. In addition to the past month, data is also presented for various time periods in the past to provide a frame of reference for measuring Program progress.

Sequence	Category of Service

Suggested Totals and Summaries

In addition to the individual page for each category of service, a total page should be produced summarizing all services combined.

3.7.4 REVIEW PROCEDURES

General

The Operational Performance Summary report should be analyzed by initially reviewing the summary page of the

report containing totals computed for all categories of service combined. If any unusual conditions are noted, the pages containing the individual service categories can be examined to identify the provider group or claims processing unit responsible for the irregularity. The review should always include a comparison of the entries for the current report month to the entries reflecting processing experience in the past. Detection of any adverse change, not explainable by known factors, should be investigated through analysis of the appropriate supporting MARS reports cited in Section 3.7.1. In reviewing the volume of claims still in process within the system at month end (report item 8.11) and the potential liability that these claims represent (report item 8.12) it is important to recognize that these figures may be greatly influenced by a sharp rise in claim receipts during the month. For this reason the ratio in report item 8.13 is probably a better index for evaluating claim thruput performance.

Suggested Action

- A steadily increasing trend in total claims processed (report item 8.Ø1) should initiate planning to cope with the additional demand for computer time that can be expected in the future. An increase may also be apparent in the average days from claim entry to approval (report item 8.Ø8) indicating a corresponding need for additional staff to process the expanding workload.
- The percentage of claims approved without suspension (report item 8.Ø3) is in large part a measure of the performance of the claims data entry operation and the claims manual review and coding process. A decline in this percentage indicates that a detailed review of the the Error Distribution Analysis (MR-O-11) is in order.

Bill Shively

- The average number of errors detected per claim (report item 8.Ø5) is often a reflection of provider claim filing performance. A marked increase in this figure warrants a review of the Error Frequency Analysis (MR-O-18) to identify individual providers with poor claim error experience.

- The percentage change to the claim suspense file during the month (report item 8.Ø6) is indicative of the effectiveness of the claim error correction unit. Steady increases to the suspense file should be investigated through the Claims Processing Performance Analysis (MR-O-Ø9). Revised corrective action procedures, supplemental staff, or additional training may be needed.

- Elapsed time from service date to date of entry of the claims into the system (report item 8.Ø7) is a factor directly controlled by the individual providers. To identify the providers responsible for long delays in claim filing, consult the Provider Claim Filing Details report (MR-O-16).

- Elapsed time from entry of claims into the system to their approval for payment (report item 8.Ø8) is a critical measure of the effectiveness of the claims processing operation. The Claims Processing Thruput Analysis (MR-O-1Ø) should be analyzed if a problem is apparent in this area.

- The sum of the charges on claims remaining in process at month's end (report item 8.12) represents a potential liability against the Program that will become due sometime in the future. This information can be of particular value as the fiscal year draws to an end and certain monies must be encumbered or when budget estimates must be prepared for state legislative appropriation hearings.

RUN DATE 6/30/72
MONTH OF 6/72

OPERATIONAL PERFORMANCE SUMMARY

CATEGORY OF SERVICE		THIS MONTH	SAME MONTH LAST YEAR	SIX MONTH AVG THIS YEAR	*** FISCAL YEAR-TO-DATE *** THIS YEAR	LAST YEAR
PHYSICIAN SERVICES						
TOTAL CLAIMS PROCESSED	8.01	54,736	52,810	53,650	651,832	596,840
PERCENT APPROVED	8.02	92.2 %	90.3 %	92.4 %	91.4 %	88.3 %
PERCENT APPROVED WITHOUT SUSPENSION	8.03	80.2 %	79.7 %	80.1 %	79.9 %	76.5 %
PERCENT REJECTED	8.04	3.6 %	7.2 %	5.4 %	5.8 %	8.1 %
AVERAGE ERRORS PER CLAIM	8.05	.15	.23	.19	.20	.24
PERCENT CHANGE IN SUSPENSE FILE	8.06	27.1 %-	4.1 %			
AVERAGE DAYS FROM SERVICE DATE TO ENTRY	8.07	10.5	15.3	9.2	10.3	17.7
AVERAGE DAYS FROM ENTRY DATE TO APPROVAL	8.08	22.2	21.4	22.8	21.1	21.3
AVERAGE DAYS FROM APPROVAL TO PAYMENT	8.09	1.3	1.5	1.4	1.1	1.3
AVERAGE DAYS FROM ENTRY DATE TO PAYMENT	8.10	23.5	22.9	24.2	22.2	22.6
CLAIMS IN PROCESS AT MONTH END	8.11	17,501	17,288	17,366	17,301	19,866
TOTAL CHARGE AMOUNT OF CLAIMS IN PROCESS AT MONTH END	8.12	205,812	236,829	206,950	205,344	268,440
NUMBER OF CLAIMS IN PROCESS AT MONTH END AS A PERCENT OF TOTAL CLAIMS RECEIVED THIS MONTH	8.13	38.5 %	46.9 %	40.3 %	39.4 %	44.1 %

3.7.6 REPORT ITEM DESCRIPTION

OPERATIONAL PERFORMANCE SUMMARY

Item Number	Item Name and Description
8.Ø1	TOTAL CLAIMS PROCESSED - The number of claims processed by the claims processing system. This count includes new claims received during the month plus claims released from the suspense file.
8.Ø2	PERCENT APPROVED - The percent of the total claims processed that were approved for payment.
8.Ø3	PERCENT APPROVED WITHOUT SUSPENSION - The percent of the total claims processed that were approved for payment without being placed on the suspense file pending error correction.
8.Ø4	PERCENT REJECTED - The percent of the total claims processed that were denied or returned to the provider for error correction.
8.Ø5	AVERAGE ERRORS PER CLAIM - The total number of claim errors detected divided by the total number of claims processed.
8.Ø6	PERCENT CHANGE IN SUSPENSE FILE - The change in the size of the suspense file from the beginning of the month to the ending of the month expressed as a percent of the beginning month claim count.
8.Ø7	AVERAGE DAYS FROM SERVICE DATE TO ENTRY - The average number of elapsed days from the last date of service on the claim to the date the claim is received by the claims processing agency.

Item Number	Item Name and Description
8.Ø8	AVERAGE DAYS FROM ENTRY DATE TO APPROVAL - The average number of elapsed days from the date the claim is received by the claims processing agency to the date the claim is approved for payment by the claims processing system.
8.Ø9	AVERAGE DAYS FROM APPROVAL TO PAYMENT - The average number of days from the date the claim is approved for payment to the date the check to the provider is written.
8.1Ø	AVERAGE DAYS FROM ENTRY DATE TO PAYMENT - The average number of days from the date the claim is received by the claims processing agency to the date the check to the provider is written.
8.11	CLAIMS IN PROCESS AT MONTH END - The number of claims in the suspense file at the end of the month. The Fiscal Year To Date columns contain a monthly average to date.
8.12	TOTAL CHARGE AMOUNT OF CLAIMS IN PROCESS OF MONTH END - The total of all charges shown on claims in the suspense file at month end. The Fiscal Year To Date columns contain a monthly average to date.
8.13	NUMBER OF CLAIMS IN PROCESS AT MONTH END AS A PERCENT OF TOTAL CLAIMS RECEIVED THIS MONTH - The number of claims in the suspense file at month end divided by the number of new claims received during the month. The Fiscal Year To Date columns contain a monthly average to date.

3.8 CLAIMS PROCESSING PERFORMANCE ANALYSIS

3.8.1 REPORT CHARACTERISTICS

MMIS Output Number:	MR-O-Ø9	
Distribution:	Data Processing Manager	
Frequency:	Monthly	
Glossary Terms:	Approved	Errors
	Rejected	Suspended

Relationship to Other MARS Reports

The Claims Processing Performance Analysis is one of a series of MARS reports concerned with the level of performance of the claims processing operation. The Claims Processing Performance Analysis looks at the workload of the Medicaid data processing system. The Claims Processing Thruput Analysis (MR-O-1Ø) measures the length of time from claim receipt by the State Agency to claim approval by the State Agency. The Error Distribution Analysis (MR-O-11) examines the extent and nature of errors detected in the claims. The Error Frequency Analysis (MR-O-18) presents individual provider statistics concerning claim error experience. The salient data from each of the above reports is summarized in the Operational Performance Summary (MR-O-Ø8) for senior management.

3.8.2 REPORT PURPOSE

The Claims Processing Performance Analysis is intended primarily for the use of the manager with responsibility for the Medicaid data processing functions. There are several importance purposes for the Performance Analysis report:

a. To provide an overview of that portion of the claims processing operation which involves computer systems. Data is compiled describing the level of activity through the data processing systems with particular

attention focused on claims not passing data edits, verification steps, and validation checks. Claims failing one or more of these checks are placed on a computer suspense file to await corrective action and subsequent re-processing through the system. Maintenance of a minimum suspense file balance should be a critical management concern.

b. To serve as a source of comprehensive statistics concerning claim processing activity for the month. Because all claims ultimately paid must pass through the data processing system, this operation becomes a convenient point at which to compile certain claim volume statistics on claim receipts, approvals, rejections, suspensions, and re-cycles.

c. To identify possible problems in the claims processing operation, both in the clerical area as well as the data processing area. An example might be the observance of a marked increase in the computer suspense file level which would suggest a possible problem in the claim error correction process.

3.8.3 REPORT ORGANIZATION

General

The Claims Processing Performance Analysis provides a comprehensive set of statistics describing the results of claims processing activities for a given month. The statistics are broken out by selected major categories of service with summary totals furnished for all claims processed, irregardless of type of claim.

The Performance Analysis is designed to provide an accounting of all claims handled by the Medicaid data processing system during the month and to reflect the disposition of these claims as of the end of the month. The report is organized into three sections:

a. New Claims - Reflecting the disposition of the claims that entered the system for the first time during the month.

b. Suspended Claims - reflecting the disposition of both claims located on the computer suspense file at month's beginning and claims that were added during the course of the month's processing.

c. Total Claims - reflecting the disposition of all claims processed during the month including new claims entering the system and claims released from the suspense file for re-processing.

The disposition of claims (i.e., approved, rejected, or suspended) is shown in each section in terms of the absolute number and the percentage which that number represents of the claim beginning balance in that section. Also shown is the suspended claim balance at month end and the net change in the suspense file between the beginning of the month and the end of the month.

Exclusions and Limitations

The section of the Performance Analysis concerned with new claims was described as containing only claims entering the computer system for the first time. Further clarification is in order on this point concerning claims which have previously been rejected and returned to the provider. Such rejects represent claims that could not be processed by the system for one or more reasons. An example might be a claim for a recipient who is ineligible at the time the service was rendered. Claims of this nature on occasion may be resubmitted by the provider to the State with or without changes in claim data. The Performance Analysis treats such a claim resubmittal as a new claim received that month.

Other Considerations

The MMIS provides an optional claims processing module for early identification of claims. This module provides the ability to locate claims received by the claims processing department but not yet fully entered into the computer system. States will require the early identification module only when they are unable to prepare claims for data entry in a reasonable time span. For this reason the report as presented does not reflect claims that might be in some processing stage preparatory to entry into computer processing. If a State should require the early identification module, a report item should be added to this report to reflect those claims received but not yet submitted to the computer system for full processing.

It should be recognized that claims may be suspended for reasons other than expected claim error conditions such as provider clerical errors, data entry errors, and claims processing coding errors. A typical example of an error-free suspension occurs when a claim is suspended for prepayment medical review and is subsequently deemed payable. Suspensions also occur due to errors that are not related to individual claims. For example, a missing reference file entry, such as diagnosis code, would cause all claims that contain the missing diagnosis code to be suspended. Claims that should be rejected may be suspended until a manual review is conducted and a force code is used to make the rejection. Thus a rejection of a suspended claim causes a single claim to be counted both as an error and a rejection. States adopting the MMIS may choose to classify error conditions like those mentioned above into separate categories on reports that present suspension and error rates. A classification of error conditions would allow management to more effectively measure claims processing performance.

3.8.4 REVIEW PROCEDURES

General

The Claims Processing Performance Analysis provides information for a one month period by select categories of service as well as totals for all categories of service. Review of the report should begin with examination of the total column representing all claims processed. In order to identify any adverse trends it will be necessary to compare the current month statistics with prior months. If any report items indicate an undesirable situation, an examination should be made of the category of service columns to isolate which type of claim(s) is responsible for the adverse change.

Suggested Action

- If a problem, such as a marked increase in claim rejections or suspensions for a certain type of claim, should appear unexpectedly one month, the Error Distribution Analysis (MR-O-11) should be examined to determine if any new error conditions have arisen in the list of the most prevalent error conditions encountered in claims. A review of the Error Frequency Analysis (MR-O-18) will identify the specific providers with a marked increase in claim error rates. Based on these findings it should be possible to pinpoint the source of the increase in claim rejections or suspensions.

- Any significant increase which is observed in the percentage of claims rejected, either new claims (report item 9.Ø5) or released suspense claims (report item 9.15), would suggest the need to investigate the computer system claim edit routines. Such a review would be for the purpose of verifying that all reject logic is proper and has not been invalidated by some new Program policy change affecting

provider submitted claim data and consequently computer edit criteria. Every attempt should be made to insure that claim rejections occur for valid reasons only. Improper claim rejects will usually be re-filed and the original processing effort and cost must be unnecessarily duplicated.

- A marked increase in the percentage of new claims suspended (report item 9.Ø7) would indicate a problem with a variety of potential causes. Poor performance by the clerical staff in assigning codes to define the circumstances of the services rendered may be the cause. A recent shifting of clerical responsibilities may require an extensive re-training effort. An analysis of the nature of the claim errors being encountered may indicate that the problem lies in unsatisfactory performance in the data entry area. Additional training might be called for in this area. An examination of the computer system claim edits may also be in order since improper or imprecise computer checks will obviously have a direct impact on the number of claims being suspended.

- A steady increase in the number of claims in suspense with respect to the number of new claims being received (report item 9.32) and an increase in the percentage of suspense claims not released during the month (report item 9.2Ø) both point to a possible overload of the clerical staff responsible for resolving claim errors and preparing appropriate corrections to process against the suspense file. There might be a need for additional clerical personnel to support this function or additional training may be necessary.

- The appearance of a relatively large number of claims suspended more than once (report items 9.Ø9 and 9.18) could reflect a problem in error correction procedures,

either in the clerical action taken or within the computer programs themselves. A review of the clerical corrective action steps established to deal with each type of error condition might be advisable if there has been a turnover in personnel in the error correction unit. The computer programs should also be inspected to insure proper error detection logic is being employed and that the system is reporting all error conditions in clear, definitive terms that are not subject to misinterpretation by the error correction clerks.

RUN DATE 6/30/72

MONTH OF 6/72

CLAIMS PROCESSING PERFORMANCE ANALYSIS

		** CATEGORY OF SERVICE **							
		INPATIENT	OUT-PATIENT	NURSING HOMES	PHYSICIAN SERVICES	PRESC DRUGS	PERIODIC SCREEN	OTHER	TOTAL ALL CAT.
NEW CLAIMS	9.01	4,712	5,167	2,951	46,646	152,251	1,278	2,285	215,290
NUMBER NEW CLAIMS APPROVED	9.02	4,612	5,063	2,910	44,314	144,662	1,257	2,103	204,921
PERCENT APPROVED	9.03	97.6 %	97.8 %	98.5 %	94.6 %	95.3 %	98.8 %	92.1 %	94.8 %
NUMBER NEW CLAIMS REJECTED	9.04	49	40	12	1,399	6,090	6	137	7,733
PERCENT REJECTED	9.05	1.3 %	1.4 %	0.1 %	3.3 %	4.2 %	0.4 %	6.1 %	4.3 %
NUMBER NEW CLAIMS SUSPENDED	9.06	51	64	29	933	1,499	15	45	2,636
PERCENT SUSPENDED	9.07	1.2 %	1.1 %	1.2 %	2.1 %	1.3 %	1.4 %	2.3 %	I.1 %
PERCENT SUSPENDED THEN RELEASED	9.08	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %
PERCENT SUSPENDED MORE THAN ONCE	9.09	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %
BEGINNING MONTH SUSPENDED BALANCE	9.10	1,245	1,987	212	24,038	190,692	2,392	3,057	233,623
CLAIMS RELEASED	9.11	198	65	65	8,090	116,968	1,270	1,890	128,650
NUMBER SUSPENDED CLAIMS APPROVED	9.12	124	136	43	6,422	96,940	982	1,690	106,337
PERCENT APPROVED	9.13	9.7 %	7.0 %	20.1 %	27.3 %	51.0 %	41.3 %	54.8 %	47.6 %
NUMBER SUSPENDED CLAIMS REJECTED	9.14	14	20	8	1,048	8,609	216	96	10,011
PERCENT REJECTED	9.15	1.2 %	1.4 %	4.3 %	4.4 %	4.8 %	9.3 %	3.3 %	4.2 %
NUMBER SUSPENDED AGAIN	9.16	30	42	14	620	11,420	72	104	12,302
PERCENT SUSPENDED	9.17	2.1 %	1.7 %	7.3 %	3.2 %	5.8 %	3.4 %	3.2 %	6.1 %
PERCENT SUSPENDED MORE THAN TWICE	9.18	0.0 %	0.0 %	3.3 %	1.1 %	1.9 %	0.0 %	0.0 %	1.2 %
CLAIMS NOT RELEASED	9.19	1,077	1,789	147	15,948	73,723	1,122	1,167	94,973
PERCENT NOT RELEASED	9.20	87.0 %	90.2 %	69.0 %	66.0 %	66.5 %	38.9 %	37.7 %	41.9 %
TOTAL CLAIMS PROCESSED	9.21	4,880	5,365	3,016	54,736	269,220	2,548	4,151	343,940
TOTAL CLAIMS APPROVED	9.22	4,736	5,199	2,953	50,736	241,602	2,239	3,793	311,258
PERCENT APPROVED	9.23	97.2 %	97.6 %	98.3 %	92.2 %	90.4 %	88.1 %	90.6 %	90.4 %
TOTAL CLAIMS REJECTED	9.24	63	60	20	2,447	14,699	222	233	17,744
PERCENT REJECTED	9.25	1.2 %	1.3 %	0.4 %	3.6 %	5.5 %	9.3 %	6.4 %	5.4 %
TOTAL CLAIMS SUSPENDED	9.26	81	106	43	1,553	12,919	87	149	14,938
PERCENT SUSPENDED	9.27	1.6 %	1.1 %	0.3 %	4.2 %	4.1 %	2.6 %	3.0 %	4.2 %
PERCENT SUSPENDED MORE THAN ONCE	9.28	1.1 %	1.2 %	0.4 %	0.6 %	4.1 %	3.0 %	2.2 %	4.1 %
SUSPENDED CLAIM BALANCE MONTH END	9.29	1,158	1,895	190	17,501	86,642	1,209	1,316	109,911
NET SUSPENSE FILE CHANGE	9.30	87-	92-	22-	6,537-	104,050-	1,183-	1,741-	113,712
PERCENT CHANGE IN SUSPENSE FILE	9.31	7.2 %-	5.3 %-	10.1 %-	27.1 %-	55.1 %-	49.4 %-	57.1 %-	51.3 %
NO. CLAIMS IN SUSPENSE AS A % OF NEW CLAIMS	9.32	25.3 %	37.1 %	6.0 %	37.8 %	56.3 %	95.5 %	58.0 %	51.0 %

3.8.6 REPORT ITEM DESCRIPTION

CLAIMS PROCESSING PERFORMANCE ANALYSIS

Item Number	Item Name and Description
9.Ø1	NEW CLAIMS - The number of claims entering the computer system for the first time this month.
9.Ø2	NUMBER NEW CLAIMS APPROVED - The number of claims approved for payment.
9.Ø3	PERCENT APPROVED - The percentage of new claims entering the system that were approved for payment without being suspended (9.Ø2 ÷ 9.Ø1 x 1ØØ).
9.Ø4	NUMBER NEW CLAIMS REJECTED - The number of new claims returned to providers.
9.Ø5	PERCENT REJECTED - The percentage of new claims entering the system that were returned to providers (9.Ø4 ÷ 9.Ø1 x 1ØØ)
9.Ø6	NUMBER NEW CLAIMS SUSPENDED - The number of new claims suspended. Claims suspended more than once are counted only once.
9.Ø7	PERCENT SUSPENDED - The percentage of new claims that were suspended (9.Ø6 ÷ 9.Ø1 x 1ØØ).
9.Ø8	PERCENT SUSPENDED THEN RELEASED - The percentage of new claims that were suspended and subsequently released for approval, rejection, or resuspension.
9.Ø9	PERCENT SUSPENDED MORE THAN ONCE - The percentage of new claims that were suspended, subsequently released for approval, and then resuspended again during the first month the claim was in the system.

Item Number	Item Name and Description
9.1Ø	BEGINNING MONTH SUSPENDED BALANCE - The number of claims that were in a suspended status at the start of this month.
9.11	CLAIMS RELEASED - The number of claims that were in a suspended status at the start of this month but were subsequently released for processing.
9.12	NUMBER SUSPENDED CLAIMS APPROVED - The number of claims that were in a suspended status at the start of this month and subsequently released and approved for payment.
9.13	PERCENT APPROVED - The percentage of claims that were in a suspended status at the start of this month and then subsequently released and approved for payment (9.12 ÷ 9.1Ø x 1ØØ).
9.14	NUMBER SUSPENDED CLAIMS REJECTED - The number of claims in a suspended status at the start of the month that were released for processing and subsequently rejected.
9.15	PERCENT REJECTED - The percentage of claims in a suspended status at the start of the month that were released for processing and subsequently rejected (9.14 ÷ 9.1Ø x 1ØØ).
9.16	NUMBER SUSPENDED AGAIN - The number of claims in a suspended status at the start of the month that were released for processing and subsequently resuspended.
9.17	PERCENT SUSPENDED - The percentage of claims in a suspended status at the start of this month that were released for processing and subsequently resuspended (9.16 ÷ 9.1Ø x 1ØØ).

Item Number	Item Name and Description
9.18	PERCENT SUSPENDED MORE THAN TWICE - The percentage of claims in a suspended status at the start of the month that were subsequently released and resuspended two or more times this month.
9.19	CLAIMS NOT RELEASED - The number of claims in a suspended status at the start of the month that had no change in status during the month.
9.2Ø	PERCENTAGE NOT RELEASED - The percentage of claims in a suspended status at the start of the month that had no status change during the month (9.19 ÷ 9.1Ø x 1ØØ).
9.21	TOTAL CLAIMS PROCESSED - The number of claims that were processed by the claims processing system. This count includes new claims received during the month plus claims released from the suspense file.
9.22	TOTAL CLAIMS APPROVED - The number of claims that were approved for payment this month.
9.23	PERCENT APPROVED - The percentage of claims that were approved for payment this month (9.22 ÷ 9.21 x 1ØØ).
9.24	TOTAL CLAIMS REJECTED - The number of claims that were denied or returned to the provider for error correction (9.Ø4 ÷ 9.14).
9.25	PERCENT REJECTED - The percentage of claims that were denied or returned to the provider for error correction (9.24 ÷ 9.21 x 1ØØ).
9.26	TOTAL CLAIMS SUSPENDED - The number of claims that were suspended during this month's processing (9.Ø6 ÷ 9.16).

Item Number	Item Name and Description
9.27	PERCENT SUSPENDED - The percentage of claims that were suspended during this month's processing (9.26 ÷ 9.21).
9.28	PERCENT SUSPENDED MORE THAN ONCE - The percentage of claims that were suspended more than once during this month's processing.
9.29	SUSPENDED CLAIM BALANCE MONTH END - The number of claims in a suspended status at the end of the month's processing.
9.3Ø	NET SUSPENSE FILE CHANGE - The increase or decrease in the number of claims in the suspense file (9.1Ø - 9.29). A negative value indicates a decrease in the suspense file.
9.31	PERCENT CHANGE IN SUSPENSE FILE - The net change in the suspense file expressed as a percentage (9.3Ø ÷ 9.29 x 1ØØ). A negative value indicates a decrease in the suspense file.
9.32	NUMBER OF CLAIMS IN SUSPENSE AS A PERCENT OF NEW CLAIMS - The number of claims in the suspense file at month's end expressed as a percentage of all new claims processed this month (9.29 ÷ 9.Ø1 x 1ØØ).

3.9 CLAIMS PROCESSING THRUPUT ANALYSIS

3.9.1 REPORT CHARACTERISTICS

MMIS Output Number: MR-O-1Ø

Distribution: Claims Department Manager

Frequency: Monthly

Glossary Terms: Approved Errors

Relationship to Other MARS Reports

The Claims Processing Thruput Analysis is one of a series of MARS reports concerned with the level of performance of the claims processing operation. The Claims Processing Thruput Analysis measures the length of time from claim receipt by the State Agency to claim approval by the State Agency. The Claims Processing Performance Analysis (MR-O-Ø9) looks at performance of the Medicaid data processing system. The Error Distribution Analysis (MR-O-11) examines the extent and nature of errors detected in the claims. The Error Frequency Analysis (MR-O-18) presents individual provider statistics concerning claim error experience. The salient data from each of the above reports is summarized in the Operational Performance Summary (MR-O-Ø8) for senior management.

3.9.2 REPORT PURPOSE

The Claims Processing Thruput Analysis is designed to be of particular value to the manager with operational responsibility for the Medicaid Claims Processing Department. The purpose of the Thruput Analysis is to present the responsible manager with a general assessment of his department's performance in its primary function, that of adjudicating provider claims. In addition to providing a measure of overall claim processing performance, the relative processing efficiency being achieved among the different types of claims is also presented. Report data will reflect which claims require the

most time to obtain approval for payment and will provide the manager with a basis for determining what processing thruput times are deemed acceptable and what times should be considered unacceptable. In this latter role the Thruput Analysis can be utilized initially for the purpose of establishing processing goals and thereafter in the measurement of progress by the claims department toward achievement of these goals.

3.9.3 REPORT ORGANIZATION

General

The Claims Processing Thruput Analysis shows the span of time required for Medicaid claims to pass through the claim adjudication process, i.e., the elapsed time from claim receipt until claim approval. Each type of claim receiving approval during the month for payment is assigned to a specific time interval according to the number of days required for that claim to receive approval for payment. The thruput performance data is presented in terms of the cumulative percentage of claims approved for payment within time intervals of 10, 20, 30, 45, 60, and 90 days from claim receipt.

In addition a calculation is made of the average days required for approval in each individual category of service as well as for all claims grouped collectively.

Sequence — Category of Service

Other Considerations

The use of elapsed time to claim approval as a basis for measuring processing performance instead of elapsed time to claim payment was intentional. In many States the actual provider check issuance is performed by an agency other than the Title XIX State Agency and thus is a function not directly under control of Medicaid management. In such situations a claim thruput analysis based on claim

payment dates might present a false picture because of delays in check issuance that were not the fault of the Claims Processing Department. Whenever actual printing of the provider payment checks is under control of the Title XIX State Agency, then elapsed time to claim approval should be changed to elapsed time to claim payment.

3.9.4 REVIEW PROCEDURE

General

The Thruput Analysis report should be reviewed foremost each month to insure that overall claims adjudication is being accomplished in an acceptable time frame. A comparison of the report item "Average Days Required For Approval" for the current month with the past month will reveal any significant slippage in the claim adjudication process. This same report item is also useful in terms of identifying a specific type of claim that is taking an inordinately long period of time to receive approval for payment.

Any judgements as to whether a particular average time for claim approval figure is too high must, of course, take into account the category of service under scrutiny. Provider claims having relatively large quantities of data input into the system, e.g., inpatient claims, can be expected to experience a higher percentage of data input errors, data validation errors, and data crossfoot errors. The subsequent error correction process will be similarly involved and will add time to the process cycle. For these reasons the claim adjudication process for complex claims will not occur as quickly as for relatively simple claims, e.g., prescription drugs.

Suggested Action

- Instances of excessive time requirements for claim approval should be investigated as to cause and

explanation. Poor claim thruput performance can be the result of any number of reasons including problems with clerical processing steps, excessive data entry errors, improper claim filing by providers, poor claim form design, and incorrect computer edits and checks. The Error Distribution Analysis (MR-O-11) is designed to help identify the nature of the errors being experienced and consequently should be analyzed for indicators as to the cause(s) of the excessive time for claim approval. Along this same line of investigation a review of the Error Frequency Analysis (MR-O-18) might yield the source of the problem. This report displays the claim error experience of the individual providers for a particular category of service.

- The Thruput Analysis can also be of considerable value in the establishment of specific operational goals for the Claims Processing Department. To illustrate, management could set a goal for the Claims Processing Department of approving 95% of all physician claims within 20 days of their receipt by the Department. Similar performance objectives could be established for each of the other categories of service, making allowances for variances in individual claim characteristics and processing complexity. The Thruput Analysis report can then be used each month as the gauge to measure the progress of the Department in reaching the operational goals established.

RUN DATE 6/30/72
MONTH OF 6/72

C L A I M S P R O C E S S I N G T H R U P U T A N A L Y S I S

CATEGORY OF SERVICE	* * * * * * PERCENT OF CLAIMS APPROVED THIS MONTH WITHIN * * * * 10 DAYS	20 DAYS	30 DAYS	45 DAYS	60 DAYS	90 DAYS	AVG. DAYS REQUIRED FOR APPROVAL
INPATIENT SERVICES	80.2	94.3	98.1	98.1	99.2	100.0	11.1
OUTPATIENT SERVICES	81.2	89.4	98.3	98.3	99.2	100.0	11.4
NURSING HOMES	93.4	96.3	99.1	99.2	99.2	99.2	8.7
PHYSICIAN SERVICES	91.2	93.4	96.2	96.2	97.3	98.1	9.6
DENTAL SERVICES	80.4	92.4	94.5	97.3	98.2	99.3	11.3
LAB AND X-RAY	83.1	93.5	96.4	98.3	98.3	99.4	10.6
PRESCRIPTION DRUGS	95.2	96.4	99.3	99.1	99.1	100.0	9.3
HOME HEALTH	93.3	98.5	99.2	99.2	100.0	100.0	9.1
PERIODIC SCREENING	93.4	96.2	98.3	99.4	100.0	100.0	9.3
OTHER	81.2	93.4	97.3	97.3	99.3	99.3	10.6
ALL CLAIMS	90.5	94.4	98.0	98.4	98.8	99.7	9.2

3.9.6 REPORT ITEM DESCRIPTION

CLAIMS PROCESSING THRUPUT ANALYSIS

Item Number	Item Name and Description
1Ø.Ø1	PERCENT OF CLAIMS APPROVED THIS MONTH WITHIN 1Ø DAYS, 2Ø DAYS, 3Ø DAYS, 45 DAYS, 6Ø DAYS, 9Ø DAYS - Percentages of claims approved for payment by elapsed days measured from the date the claim is received by the claims processing agency to the date the claim is approved for payment by the computer system.
1Ø.Ø2	AVERAGE DAYS REQUIRED FOR APPROVAL - The average number of elapsed days from the date the claim is received by the claims processing agency to the date the claim is approved for payment by the computer system.

3.10 ERROR DISTRIBUTION ANALYSIS

3.10.1 REPORT CHARACTERISTICS

MMIS Output Number:	MR-O-11
Distribution:	Operations Provider Relations
Frequency	Monthly
Glossary Terms:	Approved Errors Error Code Rejected Override

Relationship to Other MARS Reports

The Error Distribution Analysis is one of a series of MARS reports concerned with the level of performance of the claims processing operation. The Error Distribution Analysis examines the extent and nature of errors detected in the claims. The Claims Processing Thruput Analysis (MR-O-1Ø) measures the length of time from claim receipt by the State Agency to claim approval by the State Agency. The Claims Processing Performance Analysis (MR-O-Ø9) looks at performance of the Medicaid data processing system. The Error Frequency Analysis (MR-O-18) presents individual provider statistics concerning claim error experience. The salient data from each of the above reports is summarized in the Operational Performance Summary (MR-O-Ø8) for senior management.

3.10.2 REPORT PURPOSE

The Error Distribution Analysis is intended to provide Program management with information on the most recent claim error and claim rejection rates being experienced in the Medicaid data processing systems. Management should be concerned with the elimination, to the greatest extent possible, of the causes of claim rejections. Equal attention should be given to minimizing delays in claim approval that arise out

of the temporary suspension of claims containing errors that prevent approval for payment. If a significant reduction can be achieved in error rates, a proportional reduction will occur in overall claims processing costs, since claim error correction procedures require relatively expensive special handling. The Error Distribution Analysis is designed to identify error rate problems and suggest their possible cause, e.g., inadequate provider training, faulty clerical procedures, poor form design, or unsatisfactory data entry performance.

3.10.3 REPORT ORGANIZATION

General

The Error Distribution Analysis is a one page monthly report that presents the frequency of claim errors by major category of service for the past month and the average for the most recent three month period. The frequency of claim rejections is shown in a similar manner. Also shown is the proportion of the error claims that upon subsequent investigation were determined not to be actually in error. The error condition(s) in such claims are overridden and the claim released to complete its normal processing.

In addition to the data on errors encountered by category of service, the ten most prevalent error codes and their frequency of occurrence is shown. The compilation of the most common error conditions is based on an analysis of all errors detected in claims processed during the previous one month period.

Exclusions and Limitations

The Error Distribution Analysis is designed as a one page report and consequently the number of service categories shown is limited to the major categories plus all other services lumped together as one. Individual circumstances may make it desirable to expand the report to

multiple pages and show the error rate experience for each category of service separately.

Suggested Totals and Summaries

The Error Distribution Analysis identifies only the ten most prevalent error conditions encountered. If these errors do not cover a substantial percentage of all errors encountered, the listing should be expanded to include a larger number. On occasion it may be valuable to print the frequency of occurrence of every error condition detected. This list would aid in identifying any error conditions that the computer system is not detecting and posting. Existence of this situation might be the result of faulty procedures in either the manual operation or within the computer program logic.

3.10.4 REVIEW PROCEDURES

General

The Error Distribution Analysis provides data showing where errors are occurring most frequently and what errors are most prevalent. Each month on receipt of the report a comparison should be made of the past month's error rates to the average error rate over the past three months. Any significant deterioration would indicate a problem has arisen somewhere in the claims processing operation. A comparison should also be made of the relative error rate differences among the categories of service shown. An expectation of the relative error frequency among the different categories of service can be formulated by taking into consideration the varying complexity of the different claims in terms of the amount of data input into the system and the data item crossfoots and validity checks to which the data is subjected. Unless a reason exists to the contrary, primary attention should be focused on the categories of service with the largest volume of errors.

Suggested Action

- If the average errors per claim (report item 11.12) for a given category of service shows a marked increase during the past month, as compared to the previous three month average, an investigation should be made as to the cause. The Error Frequency Analysis (MR-O-18) should be examined to see if the error rate increase is contributable to a relatively small number of providers or to the entire provider group as a whole. The former case might be the result of several newly enrolled providers not understanding the claim filing instructions; the latter case would seem to suggest a possible problem with the manual processing procedures for this type of service.

- If a large percentage of claims are requiring an override (report item 11.Ø9), the computer system should be considered a prime suspect as to the cause. An erroneous edit, validity, or crossfoot check could be producing a bogus error condition. Another cause could be complex edits, the logic of which is not precise enough to specify with certainty that a definite error condition exists. The result is claims suspended for possible or potential errors, but upon examination are determined not to contain errors requiring an override to release the claim for further processing. Of course, it should be recognized that certain errors, such as overlapping dates of service between claims, can never be designated as positive errors because of the need to further examine the circumstances surrounding the claim before making a judgement as to whether a error in fact exists.

- If the general error and rejection rates (report items 11.Ø4 and 11.11) are unsatisfactory, a number of

things could be responsible. Poor performance by the data entry unit responsible for translating the claim data into computer readable format could be the problem. The Medicaid clerical staff could be improperly coding certain claim information. The computer system could be specifying error conditions where they do not in fact exist. Providers may be completing claim forms carelessly or incorrectly. A study of the Error Frequency Analysis (MR-O-18) will determine if select providers are the problem and need assistance or if the providers as a group are experiencing similar errors, which might suggest a basic fault in the design of the claim form.

- Perhaps the most effective approach to reduce the claim error rate is to concentrate on eliminating the sources of the most prevalent error conditions. These error conditions (report item 11.13) which are encountered most frequently should be researched as to cause and a concerted effort launched through training, improved procedures, etc. to remove the causes of these problems.

ERROR DISTRIBUTION ANALYSIS

		CATEGORY OF SERVICE: INPATIENT THIS MO.	INPATIENT PREV 3 MO.	OUTPATIENT THIS MO.	OUTPATIENT PREV 3 MO.	NURSING HOMES THIS MO.	NURSING HOMES PREV 3 MO.	PHYSICIAN SERVICES THIS MO.	PHYSICIAN SERVICES PREV 3 MO.	PRESCRIP. DRUGS THIS MO.	PRESCRIP. DRUGS PREV 3 MO.	OTHER THIS MO.	OTHER PREV 3 MO.
NUMBER CLAIMS PROCESSED	(11.01)	4,880	4,622	5,365	5,622	3,016	2,860	54,736	53,620	269,220	270,819	6,723	7,741
CLAIMS APPROVED	(11.02)	4,736	4,438	5,199	5,453	2,953	2,745	50,736	49,330	241,602	249,153	6,032	7,121
PERCENT APPROVED	(11.03)	97.3 %	96.2 %	97.2 %	97.3 %	97.9 %	95.8 %	93.2 %	92.1 %	90.4 %	91.9 %	90.3 %	92.3 %
PERCENT APPROVED WITHOUT ERROR	(11.04)	92.2 %	92.9 %	94.8 %	94.1 %	96.5 %	95.7 %	92.2 %	92.3 %	95.3 %	95.8 %	94.3 %	95.1 %
PERCENT APPROVED WITH 1 ERROR CORRECTED	(11.05)	7.1 %	7.3 %	4.4 %	5.3 %	3.4 %	3.5 %	6.8 %	6.7 %	4.8 %	4.7 %	5.8 %	3.9 %
PERCENT APPROVED WITH MORE THAN 1 CORRECTED ERROR	(11.06)	1.2 %	0.0 %	1.1 %	1.3 %	0.0 %	1.2 %	1.1 %	1.4 %	0.0 %	1.0 %	0.0 %	1.1 %
TOTAL NUMBER OF APPROVED CLAIM ERRORS	(11.07)	1,170	969	804	810	121	96	9,622	9,899	22,623	19,818	962	873
ERRORS THIS SERVICE AS A PERCENT OF ALL ERRORS	(11.08)	3.4 %	3.2 %	2.3 %	2.1 %	1.3 %	1.4 %	27.3 %	30.4 %	64.2 %	60.8 %	3.2 %	3.2 %
PERCENT OF CLAIMS REQUIRING OVERRIDE	(11.09)	1.4 %	0.0 %	0.1 %	0.1 %	0.2 %	0.2 %	1.3 %	1.1 %	0.2 %	0.9 %	0.3 %	0.8 %
NUMBER CLAIMS REJECTED	(11.10)	63	60	60	62	20	19	2,447	2,286	14,699	15,033	455	622
PERCENT CLAIMS REJECTED	(11.11)	1.1 %	1.1 %	0.9 %	0.7 %	1.0 %	1.1 %	3.8 %	4.2 %	5.1 %	5.9 %	6.8 %	8.3 %
AVG. ERRORS PER CLAIM	(11.12)	.25	.22	.15	.15	.04	.04	.19	.19	.09	.08	.16	.11

TEN MOST PREVALENT ERROR CONDITIONS: (11.13)

ERROR CODE	NUMBER OF ERRORS	PERCENT OF ALL ERRORS
118	968	5.9 %
125	872	5.4 %
112	860	5.2 %
152	750	4.3 %
116	540	3.4 %
119	303	2.2 %
120	300	2.5 %
195	190	2.3 %
302	090	1.1 %
334	070	1.2 %

3.1Ø.6 REPORT ITEM DESCRIPTION

ERROR DISTRIBUTION ANALYSIS

Item Number	Item Name and Description
11.Ø1	NUMBER CLAIMS PROCESSED - The total number of claims adjudicated by the claims processing system. The columns headed "Prev 3 Mo" contain a monthly average for the three month period ending with the current month.
11.Ø2	CLAIMS APPROVED - The number of claims processed that were approved for payment.
11.Ø3	PERCENT APPROVED - The percent of the claims processed that were approved for payment.
11.Ø4	PERCENT APPROVED WITHOUT ERROR - The percent of claims approved that did not require correction of any errors.
11.Ø5	PERCENT APPROVED WITH ONE ERROR CORRECTED - The percent of claims approved that required correction of only one error.
11.Ø6	PERCENT APPROVED WITH MORE THAN ONE CORRECTED ERROR - The percent of claims approved that required correction of more than one error.
11.Ø7	TOTAL NUMBER OF APPROVED CLAIM ERRORS - The total number of corrected errors on claims approved for payment.
11.Ø8	ERRORS THIS SERVICE AS A PERCENT OF ALL ERRORS - The errors on claims in each category of service as a percent of all Medicaid claim errors encountered.

Item Number	Item Name and Description
11.Ø9	PERCENT OF CLAIMS REQUIRING OVERRIDE - The percentage of approved claims initially detected as having an error but subsequently determined not to be in error and consequently requiring application of an error override.
11.1Ø	NUMBER CLAIMS REJECTED - The number of claims that were denied or required return to the provider for error correction.
11.11	PERCENT CLAIMS REJECTED - The percent of total claims processed that were rejected.
11.12	AVERAGE ERRORS PER CLAIM - The total number of claim errors detected divided by the total number of claims processed.
11.13	TEN MOST PREVALENT ERROR CONDITIONS - The ten most frequent errors showing the identifying error codes, the number of occurrences, and the percentage each error represents of all claim errors encountered in the total claims processed.

3.11 ERROR FREQUENCY ANALYSIS

3.11.1 REPORT CHARACTERISTICS

MMIS Output Number:	MR-O-18	
Distribution:	Provider Relations Operations	
Frequency:	As Required	
Glossary Terms:	Error Code Override	Errors Rejected

Relationship to Other MARS Reports

The Error Frequency Analysis is one of a series of MARS reports concerned with the level of performance of the claim processing operations. The Error Frequency Analysis presents individual provider statistics concerning claim error experience. The Claims Processing Thruput Analysis (MR-O-1Ø) measures the length of time from claim receipt by the State Agency to claim approval by the State Agency. The Claims Processing Performance Analysis (MR-O-Ø9) looks at performance of the Medicaid data processing system. The Error Distribution Analysis (MR-O-11) examines the extent and nature of errors detected in the claims. The salient data from each of the above reports is summarized in the Operational Performance Summary (MR-O-Ø8) for senior management.

3.11.2 REPORT PURPOSE

The purpose of the Error Frequency Analysis is to provide information on individual provider experience with claim errors and claim rejections. This report can be used by supervisory personnel to determine which particular providers are the source of the preponderance of errors encountered in the claims processing operation. The report is

designed to facilitate quick identification not only of which providers are experiencing excessive claim error rates, but also which particular errors are the cause of the problems. Possession of this detailed knowledge concerning an individual provider's claims enables provider relations personnel to undertake appropriate measure to improve provider claim filing performance.

3.11.3 REPORT ORGANIZATION

General

The Error Frequency Analysis presents those providers in each category of service experiencing the highest error rates in the claims they have submitted for payment. Both the total number of claims approved and the percentage of that total approved only after one or more error corrections is shown for each individual provider. Also listed by individual provider are the most frequently occurring error conditions and claim rejection reasons involving his particular claims. The report is sequenced so that providers having the highest error rates appear first.

Sequence	Category of Service
	Average Number of Errors Per 100 Claims
	Provider Number

Exclusions and Limitations

- Providers with low volumes of Medicaid claims submitted could be omitted from this report.
- The number of providers appearing on the report could be limited through exercising a report option that would suspend printing of providers who have low claim error rates. A logical procedure might be to print only those providers whose error rate is greater than the average error rate of all providers in that category of service.

- In like manner the error condition and rejection reason experience could be limited to the most frequently encountered error codes, e.g., the ten most common codes.

Suggested Totals and Summaries

The more significant totals concerning provider claim error rates are displayed on the Error Distribution Analysis (MR-O-11).

3.11.4 REVIEW PROCEDURES

General

The major concern in the review and anlaysis process - identification of providers with high claim error experience - is in effect accomplished through preparation of the report since the report is in decreasing order of providers with the highest error rates. Providers reflecting unsatisfactory performance in the filing of claims should be counseled as to appropriate steps that they can take to eliminate claim errors and therein reduce the time required before they receive payment.

Suggested Action

- If any one provider group as a whole exhibits an unsatisfactory error rate, conduct an analysis of the claim completion instructions to insure utmost clarity and completeness.
- Based on an analysis of the causes of the most frequent errors of those providers displaying error rates in excess of the average for their group, prepare bulletins pointing out the sources of the common errors and offering suggestions, where possible, to improve provider claim preparation and filing procedure. Reductions in claim error rates will yield dividends not

only by reducing the high costs associated with correcting and reprocessing error claims, but will reduce delays in claim payments and remove a principal source of provider dissatisfaction.

- High error rates experienced by high volume providers warrant individual attention that may even include visits to the providers' facilities to assist provider billing clerks to gain a complete understanding of all billing requirements as well as how to deal with any special cases.
- Investigate any instances of frequent overriding of claim errors to insure that the reasons for such action are valid and justified. Excessive overrides of a given error condition might suggest that the logic established for that error is not precise enough, or may even be improper. The computer programs may require examination to insure that the intended error logic is in fact being performed correctly.

RUN DATE 6/30/72

MONTH OF 4/72 THRU 6/72

E R R O R F R E Q U E N C Y A N A L Y S I S

CATEGORY OF SERVICE	PROVIDER NUMBER	NUMBER OF CLAIMS PAID	PERCENT PAID AFTER 1 OR MORE ERRORS	NUMBER OF REJECTED CLAIMS	NUMBER OF CLAIMS OVERRIDDEN	AVERAGE NUMBER OF ERRORS PER 100 CLAIMS
INPATIENT	6123456	168	3.4 %	4	6	7
	6389429	348	3.3 %	8	9	6
	6592386	213	2.1 %	5	8	6
	(18.01)	(18.02)	(18.03)	(18.04)	(18.05)	(18.06)

ERROR CODE	ERROR DESCRIPTION	PERCENT CLAIMS WITH THIS ERROR	PERCENT OF CLAIMS OVERRIDDEN WITH THIS ERROR
120	PROCEDURE CODE MISSING	3.1 %	87.3 %
125	DIAGNOSIS CODE MISSING	2.2 %	72.4 %
(18.07)	(18.08)	(18.09)	(18.10)

REJECTION CODE	REJECTION REASON	PERCENT OF REJECTED CLAIMS WITH THIS CODE
606	RECIPIENT NOT ELIGIBLE	38.3 %
600	CASE NUMBER NOT ON FILE	9.2 %
(18.11)	(18.12)	(18.13)

3.11.6 REPORT ITEM DESCRIPTION

ERROR FREQUENCY ANALYSIS

Item Number	Item Name and Description
18.Ø1	PROVIDER NUMBER
18.Ø2	NUMBER OF CLAIMS PAID - The number of claims paid during the time period covered by the report.
18.Ø3	PERCENT PAID AFTER 1 OR MORE ERROR - The percent of claims in item 18.Ø2 that required correction of one or more errors prior to payment.
18.Ø4	NUMBER OF REJECTED CLAIMS - The number of claims that were denied or required return to the provider for error correction.
18.Ø5	NUMBER OF CLAIMS OVERRIDDEN - The number of claims that were paid only after manual intervention to bypass a computer edit.
18.Ø6	NUMBER OF ERRORS PER 100 CLAIMS - The average number of errors encountered for each one hundred claims paid.
18.Ø7	ERROR CODE - A numeric code assigned to identify each error condition that can be detected by the computer system.
18.Ø8	ERROR DESCRIPTION - A description of the error conditions identified by the error code.
18.Ø9	PERCENT CLAIMS WITH THIS ERROR - The percent of claims in item 18.Ø2 that required correction of this error condition.

Item Number	Item Name and Description
18.1Ø	PERCENT OF CLAIMS OVERRIDDEN WITH THIS ERROR - The percentage of claims containing this error that were paid after the error was bypassed via manual intervention.
18.11	REJECTION CODE - A numeric code assigned to identify each condition for which a claim may be denied or cause return to the provider for correction.
18.12	REJECTION REASON - A description of the reason for rejection.
18.13	PERCENT OF REJECTED CLAIMS WITH THIS CODE - The percent of rejected claims (item 18.Ø4) that were rejected for this rejection reason.

PROVIDER RELATIONS AREA

Report Number	Report Name	MMIS Output #	Report Level
3.12	Provider Participation Summary	MR-O-Ø6	Level 2
3.13	Provider Participation Analysis	MR-O-12	Level 3
3.14	Cost Settlement Analysis	MR-O-13	Level 3
3.15	Cost Settlement Details	MR-O-14	Level 4
3.16	Provider Claim Filing Analysis	MR-O-15	Level 3
3.17	Provider Claim Filing Details	MR-O-16	Level 3
3.18	Third Party Payment Analysis	MR-O-17	Level 3
3.19	Provider Ranking List	MR-O-19	Level 3
3.20	1Ø99-MED	MR-O-2Ø	Level 4
3.21	Drug Usage Analysis	MR-O-21	Level 3

3.12 PROVIDER PARTICIPATION SUMMARY

3.12.1 REPORT CHARACTERISTICS

MMIS Output Number: MR-O-06

Distribution: Administration
Provider Relations
Operations
Recipient Relations

Frequency: Monthly

Glossary Terms: Category of Service
Eligible Recipients
Participating Provider

Relation to Other MARS Reports

Other related reports that may be referred to in your review of the Provider Participation Summary are: Provider Participation Analysis (MR-O-12), Recipient Participation Summary (MR-O-22), County Participation Analysis (MR-O-23), Benefit Usage Analysis (MR-O-25) and Expenditure Analysis (MR-O-04). (Also refer to Handbook Supplement D, Section D-5330.)

3.12.2 REPORT PURPOSE

This report provides program management with data pertaining to provider activity by type of service. These summary statistics are presented by time periods as an aid to interpreting the general trend of provider activity.

3.12.3 REPORT ORGANIZATION

General

This report lists, within category of service, data pertaining to providers participating in the Medicaid Program. It does not contain data pertaining to individual providers but rather to type of provider, i.e., physicians, hospitals, etc. The statistics are presented by time periods so displayed as to facilitate comparison from one time period to another. The time periods are: this month, same month last year, six month average this year, fiscal year-to-date this year and last year.

3.12.4 REVIEW PROCEDURE

General

Determine extent of change by comparison with previous months' reports as well as noting changes from one time to another as listed on this report. The items are easily reviewed in the order in which they appear on the report. Check the number of providers participating (report item 6.02): are these increasing or decreasing significantly or are they remaining fairly constant? The key item on this report is probably the percent of providers participating in the program this month (report item 6.03), as percentages are a good means of comparison. The data pertaining to eligible recipients per participating provider (report item 6.05) is an indication of the availability and accessibility of medical services as is the number of eligible recipients per

participating provider.

Suggested Action

- If the number of enrolled (report item 6.01) and/or participating providers (report item 6.02) is decreasing, efforts should be made to determine the reasons why. Is it the result of provider dissatisfaction with the program? What are the causes of this dissatisfaction? What steps may be taken to reverse this trend in order to insure continued maximum availability and accessibility of medical care for the recipient population?

- If the percent of enrolled providers actually participating in the program (report item 6.02) this month and/or the trend is on the decrease, efforts should be made to determine the reasons. Are some enrolled providers now refusing to service Medicaid recipients? Are others located in areas inaccessible to recipients?

- An acceptable recipient/provider ratio should be established against which the item pertaining to eligible recipients per participating provider (report item 6.05) may be compared. A goal to strive for, as far as physicians are concerned, is the same physician/patient ratio as is enjoyed by the population as a whole.

- Helpful additional information, not available in this report, but related to it, would be the percentage of

enrolled and/or participating providers to the number of practicing providers in the community. According to Handbook Supplement D, "medical care and services included in the plan (should be) available to eligible persons at least to the extent they are available to the General Population." Numbers of practicing physicians may be obtained from county or State medical societies.

RUN DATE 5/3/72
MONTH OF 5/72

P R O V I D E R P A R T I C I P A T I O N S U M M A R Y

CATEGORY OF SERVICE		THIS MONTH	SAME MONTH LAST YEAR	SIX MONTH AVG. THIS YEAR	***FISCAL YEAR-TO-DATE** THIS YEAR	LAST YEAR
PHYSICIAN SERVICES						
NUMBER OF PROVIDERS ENROLLED	(6.01)	8,802	7,840	8,846	8,911	8,103
NUMBER OF PROVIDERS PARTICIPATING	(6.02)	5,721	5,149	5,556	6,700	5,933
PERCENT OF PROVIDERS PARTICIPATING	(6.03)	65.9%	65.7%	62.8%	75.2%	73.2%
CLAIMS PAID PER PARTICIPATING PROVIDER	(6.04)	16.3	17.6	16.8	16.1	17.1
ELIGIBLE RECIPIENTS PER PARTICIPATING PROVIDER	(6.05)	21.3	22.3	21.6	21.7	23.0

3.12.6 REPORT ITEM DESCRIPTION

PROVIDER PARTICIPATION SUMMARY

Item Number	Item Name and Description
6.01	NUMBER OF PROVIDERS ENROLLED - The number of providers that have agreed to participate in the Medicaid Program or, if provider agreements are not required, the number that have participated in the past.
6.02	NUMBER OF PROVIDERS PARTICIPATING - An unduplicated count of the number of providers that rendered services to Medicaid recipients in the time period shown.
6.03	PERCENT OF PROVIDERS PARTICIPATING - The number of providers participating as a percent of the providers enrolled.
6.04	CLAIMS PAID PER PARTICIPATING PROVIDER - The total number of claims paid for the category of service divided by the number of participating providers.
6.05	ELIGIBLE RECIPIENTS PER PARTICIPATING PROVIDER - The number of recipients eligible for benefits from Medicaid divided by the number of participating providers.

3.13 PROVIDER PARTICIPATION ANALYSIS

3.13.1 REPORT CHARACTERISTICS

MMIS Output Number: MR-O-12

Distribution: Administration
Provider Relations
Operations
Recipient Relations

Frequency: Monthly

Glossary Terms: Category of Service

Relation to Other MARS Reports

This report directly supports the Provider Participation Summary, by providing more statistical data regarding payments, recipients and service units per provider. Other related reports that may be referred to in your review of the Provider Participation Analysis report are: County Participation Analysis (MR-O-23), Benefit Usage Analysis (MR-O-25), Expenditure Analysis (MR-O-04), Third Party Payment Analysis (MR-O-17), and Provider Participation Summary (MR-O-06). (Also see various S/UR Summary Profile Reports and Handbook Supplement D, Section D-5330.)

3.13.2 REPORT PURPOSE

This report is intended to provide an in-depth analysis of provider participation by an examination of payments, services rendered and recipients served, by category of service. The data pertaining to provider participation are presented by

time periods in order to establish service and participation trends for planning and control.

3.13.3 REPORT ORGANIZATION

General

This report lists, within category of service, data pertaining to provider participation in relation to recipients served, third party payments, and units of service. The time periods in which the data is presented are: this month, same month last year, six-month average this year, fiscal year-to-date this year, and fiscal year-to-date last year. The data is so displayed as to facilitate comparison from one time period to another.

Sequence	Category of Service

3.13.4 REVIEW PROCEDURES

A key column in this report is the trend column. The plus or minus figures in this column are indicators of the direction and magnitude of program change. (The trends are developed by using the "least squares" method of projection and based on the previous twelve months' activity.) Though this report is provider oriented, it has several data items pertaining to recipients. To highlight this recipient data, look at the total XIX payments (report item 12.04) to determine if they are increasing. If so, has the number of recipients served (report item 12.02) increased and/or has the average payment per recipient (report item 12.06) increased, etc.? Noting that many of the items are interrelated, continue

the review in this manner to determine the basic reasons for changes in expenditure levels.

Suggested Action

- If the average payment per recipient (report item 12.06) has increased, refer to the expenditure Analysis (MR-0-04) to determine if the increase is due to an increase in payments for a particular recipient category, such as AFDC, or if there was an increase for all aid categories.

- If the average payment per service unit (report item 12.12) has increased and the average number of services per recipient (report item 12.11) has increased, determine what categories of eligibility accounted for the increase in service units by referring to the Expenditure Analysis Report (MR-0-04). An increase in the average payment per service unit may be explained by referring to the S/UR Summary Profile Reports. If changes in utilization are resulting in more expensive services, this will be reflected in these Summary Profile Reports.

- In addition to the substitution of expensive services for inexpensive ones, increases in unit prices may be explained by changes in reimbursement policy or upward trends in usual and customary charges. If the latter is suspected, the following reference file subsystem report should be requested: Reasonable Charge Listing by Provider, for comparison with previous reports.

RUN DATE 02/29/72
MONTH OF 2/72

PROVIDER PARTICIPATION ANALYSIS

CATEGORY OF SERVICE		THIS MONTH	SAME MONTH LAST YEAR	SIX MONTH AVG. THIS YEAR	TREND	FISCAL YEAR-TO-DATE THIS YEAR	FISCAL YEAR-TO-DATE LAST YEAR
PHYSICIAN SERVICES							
NUMBER OF PROVIDERS PARTICIPATING	(12.01)	5,589	4,973	5,487	.002	6,212	5,711
TOTAL RECIPIENTS SERVED	(12.02)	56,857	50,324	56,933	.998	66,468	58,252
AVG. RECIPIENTS PER PROVIDER	(12.03)	10.1	10.1	10.3	.009	10.7	10.2
TOTAL XIX PAYMENTS	(12.04)	$845,623	$776,000	$874,187	.003	$7,387,160	$7,100,812
AVG. PAYMENT PER PROVIDER	(12.05)	$151.30	$154.04	$159.31	.002	$1,189.17	$1,243.45
AVG. PAYMENT PER RECIPIENT	(12.06)	$14.87	$15.42	$15.35	.011	$14.81	$15.15
TOTAL THIRD PARTY PAYMENT	(12.07)	$46,832	$58,652	$56,333	.002	$321,911	$319,678
PERCENT CLAIMS WITH THIRD PARTY PAYMENT	(12.08)	13.0 %	14.0 %	13.5 %	.001	13.9 %	13.7 %
TOTAL UNITS OF SERVICE RENDERED	(12.09)	106,969	95,705	106,486	.015	881,186	879,325
AVG. SERVICE UNITS PER PROVIDER	(12.10)	19.1	19.2	19.4	.006	141.85	153.97
AVG. SERVICE UNITS PER RECIPIENT	(12.11)	1.8	1.9	1.8	.079	13.2	15.1
AVG. PAYMENT PER SERVICE UNIT	(12.12)	$7.93	$8.10	$8.20	.017	$8.38	$8.07

3.13.6 REPORT ITEM DESCRIPTION

PROVIDER PARTICIPATION ANALYSIS

Item Number	Item Name and Description
12.01	NUMBER OF PROVIDERS PARTICIPATING - An unduplicated count of the number of providers that rendered services to Medicaid recipients in the time period shown.
12.02	TOTAL RECIPIENTS SERVED - An unduplicated count of the number of recipients receiving Medicaid benefits during the time period shown.
12.03	AVERAGE RECIPIENTS PER PROVIDER - The number of recipients receiving benefits from Medicaid divided by the number of participating providers. (12.02 ÷ 12.01)
12.04	TOTAL XIX PAYMENTS - The Medicaid expenditure for medical services to Medicaid recipients.
12.05	AVERAGE PAYMENT PER PROVIDER - The average amount paid to participating providers for services rendered.
12.06	AVERAGE PAYMENT PER RECIPIENT - The average Medicaid expenditure for recipients receiving Medicaid benefits.
12.07	TOTAL THIRD PARTY PAYMENT - The total amount of third party payments reported by providers on submitted Medicaid claims.
12.08	PERCENT CLAIMS WITH THIRD PARTY PAYMENT - The number of claims containing payment from a third party as a percent of the total number of claims filed.

Item Number	Item Name and Description
12.09	TOTAL UNITS OF SERVICE RENDERED - The total units of service received by Medicaid recipients.
12.10	AVERAGE SERVICE UNITS PER PROVIDER - The average number of service units provided by participating providers.
12.11	AVERAGE SERVICE UNITS PER RECIPIENT - The number of service units rendered divided by the number of recipients receiving service. (12.09 ÷ 12.02).
12.12	AVERAGE PAYMENT PER SERVICE UNIT - The total Medicaid expenditure divided by the total units of service rendered. (12.04 ÷ 12.09)

3.14 COST SETTLEMENT ANALYSIS

3.14.1 REPORT CHARACTERISTICS

MMIS Output Number:	MR-O-13
Distribution:	Administration Provider Relations
Frequency:	Monthly
Glossary Terms:	Cost Settlement

Relationship to Other MARS Reports

The Cost Settlement Analysis supplies the supporting detail for report item 3.Ø5 on the Financial Summary (MR-O-Ø3).

3.14.2 REPORT PURPOSE

The purpose of the Cost Settlement Analysis is to furnish the State Agency financial planners with data concerning interim payments to-date versus expected actual costs for those providers in the Program who are reimbursed on the basis of reasonable costs. Such information is necessary to insure that the Medicaid Program does not encounter unexpected liability for provider costs at the time of provider cost settlements. This report, which is only applicable to providers paid on a per diem rate, analyzes each provider in terms of his charges versus payment pattern for the current fiscal year with respect to the previous fiscal year. For those providers indicating a rapid buildup in liability, a review and determination of the cause is advisable so that adjustments can be made to bring the interim payments into line with the expected cost settlement.

3.14.3 REPORT ORGANIZATION

General

The Cost Settlement Analysis provides an assessment of each cost settled provider's current financial standing with respect to the Medicaid Program. The assessment is based on a comparison of the interim payments for the current year charges to the final total payment that resulted the previous year after cost settlement adjustments. By expressing payments in both years as a percent of filed charges, the rate of interim payments for the current year can be evaluated in terms of the extent to which such payments approach the cost settled payment results of the previous year. The estimated dollar value of the over or under payment to date is determined by multiplying the current year claim charges by the difference in the rate of payment (percent of charges paid) between the two years.

Sequence	Category of Service
	Provider Number

Exclusions and Limitations

- Medicare crossover claims for Part A deductibles and coinsurance should not be included in the Cost Settlement Analysis as they are paid in full and do not enter into the cost settlement process for Title XIX claims.
- The Cost Settlement Analysis is applicable only to providers whose interim reimbursement is based on a per diem payment. Essentially, the Cost Settlement Analysis compares, on a percent of charges basis, the interim payments of providers paid on a per diem basis. Therefore, there would be no basis of comparison for the providers always paid on a fixed percent of charges.

- The Cost Settlement Analysis does not include payments for claims that have been received but not adjudicated. The report should be used more as an indication of the reasonableness of the interim payments than as an exacting measure of State Agency liability or overpayment.

Suggested Totals and Summaries

The total dollar value of the estimated State Agency overpayment or liability to date should be computed for each category of service and for all categories shown on the report.

3.14.4 REVIEW PROCEDURES

General

A major concern of the Cost Settlement Analysis is to provide the State Agency management responsible for financial planning and budget control with an estimate of the requirement for funds to satisfy future cost settlement obligations. In a situation where the interim per diem rates for institutions have been set too low, a significant demand can unexpectedly arise for Title XIX funds. A financial crisis can even result if the State is required to strictly stay within individual category of service (line item) budget allocations. The problem will intensify if a large number of institutional providers close out their fiscal year at approximately the same time.

Suggested Action

- If the size of total liability projected in report item 13.Ø8 amounts to a significant dollar value, Medicaid Program funds may have to be shifted to cover cost settlement obligations. If sufficient funds are not available, alternative solutions may have to be considered, such as, supplemental budget appropriations,

temporary postponements of cost settlement adjustments, or even the imposition of some type of service limitation to conserve funds.

- Each individual provider should be reviewed to determine if his per diem rate appears out of line to the extent that an immediate rate adjustment is justified. Again report item 13.Ø8 is probably the best indicator of a potential problem, but there are other important factors to consider before a detailed rate review should be undertaken:

  a. The current point of time in relation to the provider's fiscal year end. Adjustments to the per diem rate made in the last several months of a fiscal year may not be applied to enough claims to significantly influence the year-end settlement.

  b. Prior adjustments to the per diem rate. The rate may have already been adjusted in recent months and the size of the projected cost settlement liability may be growing increasingly smaller since that time, thus making no further adjustments necessary.

  c. The size of the institution. What may be considered an insignificant liability for a large (500-1000 bed) hospital might constitute a sizable liability for a relatively small (50-100 bed) hospital.

- Once the decision to adjust the per diem rate has been made, it is then necessary to determine the size of the adjustment. A recommended approach is to attempt to adjust the per diem rate so that the value of report item 13.Ø8 will approach zero by the end of the provider's fiscal year. This procedure will satisfy the objective of achieving the smallest possible year-end cost settlement.

RUN DATE 6/30/72
MONTH OF 6/72

COST SETTLEMENT ANALYSIS

CATEGORY OF SERVICE: HOSPITAL INPATIENT

PROVIDER NUMBER	LAST YEAR'S NET REIMBURSE.	LAST YEAR'S CHARGES	LAST YEAR'S REIMB. AS A % OF CHARGES	THIS YEAR'S PAYMENTS	THIS YEAR'S CHARGES	THIS YEAR'S PAYMENT AS A % OF CHARGES	OVER OR (UNDER) PAYMENT BASED ON DIFFERENCE IN LAST YEAR'S REIMB. % AND THIS YEAR'S PAYMENT %
1234567	48,018	52,628	91.2 %	48,596	52,790	92.1 %	475
1345678	95,869	106,411	90.1 %	110,073	120,321	91.5 %	1,684
1543678	67,481	75,742	89.1 %	77,968	85,123	91.6 %	2,128
1553521	463,521	511,321	90.7 %	493,622	554,169	89.1 %	(8,866)
1564523	225,386	263,646	85.5 %	241,298	287.003	84.1 %	(4,018)
(13.01)	(13.02)	(13.03)	(13.04)	(13.05)	(13.06)	(13.07)	(13.08)

3.14.6 REPORT ITEM DESCRIPTION

COST SETTLEMENT ANALYSIS

Item Number	Item Name and Description
13.Ø1	PROVIDER NUMBER
13.Ø2	LAST YEAR'S NET REIMBURSEMENT - The total amount paid to the provider for Medicaid services plus (or minus) the cost settlement adjustment determined at the end of the fiscal year. This, or any other figures on this report, does not include any payments made for Medicare deductibles or coinsurance.
13.Ø3	LAST YEAR'S CHARGES - The total amount of claim charges filed by the provider for Medicaid services rendered.
13.Ø4	LAST YEAR'S REIMBURSEMENT AS A PERCENT OF CHARGES - Item 13.Ø2 divided by item 13.Ø3 multiplied by 1ØØ.
13.Ø5	THIS YEAR'S PAYMENTS - The total amount of interim payments made in the current fiscal year-to-date period.
13.Ø6	THIS YEAR'S CHARGES - The total amount of claim charges filed by the provider for Medicaid services on claims paid in the current fiscal year-to-date period.
13.Ø7	THIS YEAR'S PAYMENT AS A PERCENT OF CHARGES - Item 13.Ø5 divided by item 13.Ø6 multiplied by 1ØØ.

Item Number	Item Name and Description
13.Ø8	OVER OR (UNDER) PAYMENT BASED ON DIFFERENCE IN LAST YEAR'S REIMBURSEMENT PERCENT AND THIS YEAR'S PAYMENT PERCENT - The estimated fiscal year-to-date cost settlement adjustment amount [(13.Ø7 - 13.Ø4) x 13.Ø6].

3.15 COST SETTLEMENT DETAILS

3.15.1 REPORT CHARACTERISTICS

MMIS Output Number:	MR-O-14
Distribution:	Administration Provider Relations
Frequency:	As Requested
Glossary Terms:	Charge Center Cost Settlement

3.15.2 REPORT PURPOSE

The Purpose of the Cost Settlement Details report is to provide the State Agency auditors responsible for institutional cost settlement with a complete accounting of all charges that a given institution has claimed against Title XIX. A summary of charges is presented by cost center and is used by State auditors to ensure that the provider's internal accounting records reflect identical Medicaid patient charges. The individual claim detail is essential to researching discrepancies in the charge summaries and to check institutional claim records on a sample basis. The claim detail is also useful in identifying the cause of unusually high charges in a particular charge center.

3.15.3 REPORT ORGANIZATION

General

There are two parts to the Cost Settlement Details report. The first part provides a summary of charges from a provider and corresponding payments to that provider over a specified time period. The second part, which is produced at the requestor's option, is a complete listing of the detail claim charges that resulted in the summary charge figures.

Sequence:

Category of Service
Provider Number
Ending Date of Service

Exclusions and Limitations

The requestor, through options entered in the report request process, can specify that the report for any provider be limited to only those claims with dates of service occurring in a specified fiscal year and paid within a specified time period. If desired, the requestor may suppress the claim detail listing portion of the report in its entirety.

Suggested Totals and Summaries

Total charges and payments, of course, appear in the first portion of the Cost Settlement Details. Intermediate totals for each monthly break in payment period or service period might also prove of value to State auditors and consequently should be considered.

3.15.4 REVIEW PROCEDURE

The Cost Settlement Details report is prepared to meet a specialized need within a State Agency and consequently has very limited circulation. Availability of this report within the State Agency financial unit responsible for institutional cost verification and cost settlement processes will enable this staff to perform its tasks more efficiently and effectively. The appropriate report should be supplied to the audit team immediately prior to the time of the visit to the provider's facilities. The auditors should use the Cost Settlement Details to identify the source of any discrepancies between the State Agency claim records and those of the institution. In addition the summary charge center amounts should be reviewed to detect an unusually high percentage of charges in a particular charge center. Such an occurrence should be investigated to insure that the

individual claims that comprise this total are correct and proper in every respect. The claim detail listing will assist the auditors in determining if claims for unusually complex and expensive procedures, such as open heart surgery, are primarily responsible for the high costs.

RUN DATE 6/01/73

PAGE NO 01

COST SETTLEMENT DETAILS

PROVIDER SUMMARY

1234567 (14.01)
GENERAL HOSPITAL
MAINSTREET (14.02)
ANYWHERE, USA

TITLE XVIII CODE: 2345678 (14.03)

FISCAL YEAR START: 8/01/71 (14.04)

FISCAL YEAR END 7/31/72 (14.05)

PAYMENT PERIOD 8/01/71 (14.06)
12/01/72

**********TOTALS**********

TOTAL CHARGES	343,556	(14.07)
AMOUNT PAID BY TITLE XIX	307,850	(14.08)
AMOUNT PAID BY 3RD PARTIES	10,262	(14.09)
AMOUNT PAID FOR TITLE XVIII DEDUCTIBLE & COINSURANCE	23,944	(14.10)

******CHARGE AMOUNTS PER CHARGE CENTER******

BLOOD	1,500	ANEST	8,652
PRIVATE RM	16,880	PHARM	9,412
SEMIPRIV.	102,340	RADIOL	28,620
WARD	96,418	LAB	19,532
INTEN CARE	30,610	SUPPLIES	8,092
OPER ROOM	15,482	PHYS THER	6,018

(14.11)

CLAIM DETAIL

PATIENT NAME	CASE NO.	CLAIM NO.	DATE PAID	SERVICE DATES	DIAG CODE	DAYS REG	DAYS NURS	*******CHARGES********		*********PAYMENTS*******		
JONES H A	123-456-789	72103-1234	5/30/72	2/12/72 2/15/72	7523	3	0	BLOOD 2-4 BED RM OP. ROOM RADIOLOGY	22.00 200.00 175.00 37.00	MEDICAID	340.00	(14.20)
								TOTAL	434.00	3RD PARTY	50.00	(14.21)
BROWN B R	125-615-384	72099-0055	5/30/72	3/01/72 3/15/72	5185	9	0	WARD RADIOLOGY LABORATORY	450.00 75.00 125.00	MEDICAID	500.00	
								TOTAL	650.00			
(14.12)	(14.13)	(14.14)	(14.15)	(14.16)	(14.17)	(14.18)			(14.19)			

3.15.6 REPORT ITEM DESCRIPTION

COST SETTLEMENT DETAILS

Item Number	Item Name and Description
14.Ø1	PROVIDER NUMBER
14.Ø2	PROVIDER NAME AND ADDRESS
14.Ø3	TITLE XVIII PROVIDER CODE - The provider number assigned to the provider by the Medicare intermediary.
14.Ø4	FISCAL YEAR START - Beginning date of provider's fiscal year covered by this report.
14.Ø5	FISCAL YEAR END - Ending date of provider's fiscal year covered by this report.
14.Ø6	PAYMENT PERIOD - Provider cost data reflects only claims for service that were both rendered in the fiscal year shown and paid by Medicaid within the payment period shown.
14.Ø7	TOTAL CHARGES - Total amount of all Title XIX claim charges filed by the provider during his fiscal year.
14.Ø8	AMOUNT PAID BY TITLE XIX - The total amount paid by Medicaid to the provider during the fiscal year.
14.Ø9	AMOUNT PAID BY THIRD PARTIES - The total amount paid by third party sources to the provider for claims on Medicaid recipients and thus reducing Title XIX liability. Medicare payments are not considered to be third party payments.

Item Number	Item Name and Description
14.1Ø	AMOUNT PAID FOR TITLE XVIII DEDUCTIBLE AND COINSURANCE - The amount paid by Medicaid to the provider for deductible and coinsurance amounts not paid by Medicare. This amount is included in item 14.Ø8.
14.11	CHARGE AMOUNTS PER CHARGE CENTER - The total amount of claims charges (item 14.Ø7) broken out by the individual charge centers used by providers in accounting for patient costs.
14.12	PATIENT NAME - Name of recipient whose individual claim detail is shown.
14.13	CASE NUMBER - Medicaid identification number of recipient whose claim is shown.
14.14	CLAIM NUMBER - Number assigned by claims processing agency to provide a unique identification for recipient claim shown.
14.15	DATE PAID - Date check was issued to provider covering payment of claim shown.
14.16	SERVICE DATES - Inclusive dates on which services were rendered for claim shown.
14.17	DIAGNOSIS CODE - ICDA code relating to the services indicated on the claim shown.
14.18	DAYS REGULAR/NURSERY - The number of patient days and infant days (where applicable) covered by the claim shown.
14.19	CHARGES - The individual charges incurred in the provider charge centers for the claim shown.
14.2Ø	MEDICAID PAYMENT - Total amount of Title XIX payment for claim shown.

Item Number	Item Name and Description
14.21	3RD PARTY PAYMENT - Total amount of third party payment that was applied against the charges for the claim shown.

3.16 PROVIDER CLAIM FILING ANALYSIS

3.16.1 REPORT CHARACTERISTICS

MMIS Output Number:	MR-O-15
Distribution:	Administration Provider Relations
Frequency:	Monthly
Glossary Terms:	Approved

Relationship to Other MARS Reports

The Provider Claim Filing Analysis is supported by the Provider Claim Filing Details report (MR-O-16). The Provider Claim Filing Analysis presents a comparison between the different categories of service with respect to time required to file Medicaid claims while the Provider Claim Filing Details report identifies the individual providers responsible for excessive claim filing delays.

3.16.2 REPORT PURPOSE

The Provider Claim Filing Analysis is designed to satisfy a two-fold purpose:

a. To identify by category of service, the length to of time that transpires between the time the provider renders the service and the time the provider forwards the claim to the claims processing agency. Through this report, management can monitor progress toward attainment of the objective of minimizing claim filing delays. A recommended plan might be to encourage provider filing of all claims within thirty days of the last date of service. In many states a Medicaid Program policy has been established that requires claims to be filed in a relatively short (30-60 days) period of time following the last date of service.

Elimination of claim filing delays is important as significant delays can distort financial and statistical reports. A good example of the need for prompt filing by providers can be found in the MMIS Surveillance and Utilization Review (S/UR) Subsystem. The S/UR subsystem processes claims on a date of service basis. Lengthy delays in filing of claims will cause the most recent time periods on the surveillance reports to reflect considerably fewer claims than prior time periods and any conclusions based on a comparison between periods could be meaningless.

b. To make financial management aware of the magnitude of the liability that is continuously outstanding for claims where the service has been rendered but the claims have not as yet been received. In some states the ability to project the cost of claims that will be received after the end of a fiscal year is critical due to legal restrictions limiting the use of current funds to pay for obligations incurred in the previous fiscal year. Knowledge of unfiled claims liability is also helpful in comparing actual Program costs to amounts established in the Program budget.

3.16.3 REPORT ORGANIZATION

General

The Provider Claim Filing Analysis presents, for each major category of service, a distribution for the claims paid during the past month of the elapsed time between the last date of service on a claim and the date that claim was received by the claims processing agency. The time intervals presented are one, two, and three months, four to six months, and greater than six months. Shown for each time interval is the number of claims, their payment amount, and

the percent of total claims paid during the month that these claims represent. The total number of claims, their value, and the average days elapsing prior to claim receipt is shown for providers in each major category of service.

Exclusions and Limitations

- Claims for payment of Medicaid deductibles and coinsurance should be excluded from this report as providers cannot be held responsible for crossover claim filing delays which most often are caused by the Medicare intermediary or carrier.
- This report will not be useful to Medicaid Programs that have established relatively short (30-60 days) claim filing requirements for their participating Medicaid providers.

3.16.4 REVIEW PROCEDURES

General

The Provider Claim Filing Analysis report should be reviewed to determine which categories of service, if any, are experiencing significant delays in claim filing. A significant delay might be defined as occurring if ninety-five percent of the claims for a category of service are not received within 60 days of the last date of service on the claim. Report item 15.Ø4 depicts the number of claims filed within a thirty day time periods. To determine the number of claims filed within sixty days, the number of claims filed between the thirty-first and sixtieth days must be added to the first thirty day figure. Progress toward achieving a decrease in claim filing delays may be measured by comparing the current month figures to those in reports of previous months.

Suggested Action

- If all, or a large number, of the categories of service show a substantial or increasing tendency to delay the filing of claims, providers should be reminded of their responsibility as a participant in the Medicaid Program. Perhaps a general memorandum attached to a check for payment for Medicaid services or a more direct communication by personal letter could be used to encourage providers to improve their filing habits. If persuasion of providers does not achieve the desired effect, consideration should be given to establishing a Medicaid policy requiring claims to be filed within a certain time period.

- It may happen that a minority of providers within a category of service are primarily responsible for excessive claim filing delays. To determine if this is the case, another report, Provider Claim Filing Details (MR-O-16), is available upon request. This report can be produced to show, by individual provider within category of service, the average days elapsing before claim filing, the number of claims filed, and the value of claims filed for the same time period reflected in the Provider Claim Filing Analysis. The data is presented by provider in descending order of average days to filing. Rather than getting a complete report, the request should be limited to those categories of service that indicate the greatest cause for concern. Suggestions for dealing with individual providers are included in the discussion of the Provider Claim Filing Details report.

RUN DATE 06/30/72

MONTH OF 6/72

PROVIDER CLAIM FILING ANALYSIS

		INPATIENT	OUTPATIENT	NURSING HOMES	PHYSICIAN SERVICES	DENTAL SERVICES	LAB AND X-RAY	PRESCRIP. DRUGS	OTHER SERVICES	TOTAL ALL CATEGORIES
TOTAL CLAIMS APPROVED	(15.01)	4,736	5,199	2,953	50,736	3,006	356	241,602	2,670	311,258
TOTAL AMOUNT PAID	(15.02)	731,409	58,983	945,276	596,672	60,765	3,306	929,736	25,915	3,352,062
AVERAGE DAYS TO FILING	(15.03)	35	28	10	12	17	25	14	18	20
CLAIMS RECEIVED IN 1-30 DAYS FROM LAST DATE OF SERVICE:	(15.04)	2,936	3,795	2,775	47,691	2,404	242	236,769	2,189	298,801
PERCENT OF TOTAL CLAIMS APPROVED	(15.05)	62%	73%	94%	94%	80%	68%	98%	82%	87%
AMOUNT OF PAYMENT	(15.06)	453,473	43,057	888,559	560,871	48,612	2,248	911,141	21,250	2,929,211
CLAIMS RECEIVED IN 31-60 DAYS FROM LAST DATE OF SERVICE:		1,420	1,144	89	2,029	511	89	2,416	429	8,125
PERCENT OF TOTAL CLAIMS APPROVED		30%	22%	3%	4%	17%	25%	1%	16%	3%
AMOUNT OF PAYMENT		219,422	12,976	28,358	23,866	10,330	827	9,297	4,146	309,222

(REPEAT FOR -
61-90 DAYS
4-6 MONTHS
MORE THAN 6 MONTHS)

3.16.6 REPORT ITEM DESCRIPTION

PROVIDER CLAIM FILING ANALYSIS

Item Number	Item Name and Description
15.Ø1	TOTAL CLAIMS APPROVED - The number of claims approved for payment in the month covered by the report.
15.Ø2	TOTAL AMOUNT PAID - The amount paid by Medicaid to providers for the claims approved for payment in report item 15.Ø1.
15.Ø3	AVERAGE DAYS TO FILING - The average number of days from the last date of service on a claim to the date the claim was received by the claims processing agency for all claims in report item 15.Ø1.
15.Ø4	CLAIMS RECEIVED IN 1-3Ø DAYS, 31-6Ø DAYS, 61-9Ø DAYS, 4-6 MONTHS, MORE THAN 6 MONTHS FROM LAST DATE OF SERVICE - The number of claims shown in report item 15.Ø1 that were received within the time intervals listed. The time intervals are a measure of the days between the last date of service and the date the claim was received by the claims processing agency.
15.Ø5	PERCENT OF TOTAL CLAIMS APPROVED - The percent of Total Claims Approved (report item 15.Ø1) represented by the claims shown in each time interval listed in report item 15.Ø4.
15.Ø6	AMOUNT OF PAYMENT - The amount of payment by Title XIX for claims filed in the time interval listed in report item 15.Ø4.

3.17 PROVIDER CLAIM FILING DETAILS

3.17.1 REPORT CHARACTERISTICS

MMIS Output Number: MR-O-16

Distribution: Provider Relations

Frequency: As Requested

Relationship to Other MARS Reports

The Provider Claim Filing Details provides claim filing experience information on selected providers. The Provider Claim Filing Analysis (MR-O-15) indicates the categories of service in which claim filing delays are most prevalent. The need for the detail report is determined through study of the Provider Claim Filing Analysis.

3.17.2 REPORT PURPOSE

The purpose of the Provider Claim Filing Details is to assist provider relations personnel in determining those providers primarily responsible for any excessive delays in filing Medicaid claims. Once the delinquent providers have been identified, this report, as well as the Provider Claim Filing Analysis (MR-O-15), should be used as justification for requesting better cooperation from the providers with regard to prompt claim filing, or achieving little success in this approach, justification for establishing claim filing deadlines. This report will not be applicable to the Medicaid Programs that have already adopted a policy setting forth claim filing limitations.

3.17.3 REPORT ORGANIZATION

General

The Provider Claim Filing Details report presents the claim filing characteristics of providers within a category of service. The number of elapsed days between the last date of service on the claim and the date the claim is

received by the claim processing agency is shown in terms of an average and as a frequency distribution for each selected provider. The time intervals of one, two, and three months, four to six months, and greater than six months are the same as the intervals shown on the Provider Claim Filing Analysis (MR-O-15).

Sequence	Category of Service Average Days To Filing (descending order)

Exclusions and Limitations

- This report is produced on an as requested basis. The capability to request only selected categories of service is provided. The Provider Claim Filing Analysis is designed to assist in the identification of categories of service with the greatest claim filing delays.
- Providers are sequenced in descending order of their average days to filing, which causes the providers exhibiting the greatest filing delay to appear at the beginning of the report. Through an option in the report request procedure, the number of providers appearing on the report may be limited. A suggested limitation is to print only those providers whose average days to filing is greater than the average for all providers in that category of service.
- Extremely low volume providers should be excluded from the report as the greatest improvement in timely claim filing will best be attained through concentration on the higher volume providers.
- Claims for payment of Medicare deductibles and coinsurance should be excluded from this report as providers cannot be held responsible for crossover claim filing delays caused by the Medicare intermediary or carrier.

3.17.4 REVIEW PROCEDURES

General

The providers selected by the Provider Claim Filing Details report should be contacted and urged to improve their claim filing habits. Staffing limitations may dictate that more than one technique be applied to the problem. The higher volume providers with the greatest average delay offer the most potential for improvement and therefore should receive the most attention. These providers may be selected through analysis of report item 16.Ø2, Average Days To Filing, and the relative number and value of their filed claims.

Suggested Action

- Discussions concerning claim filing delays should be held with large volume providers as part of regular visits by provider relations field personnel. Emphasis should be placed on the advantages to the individual provider as well as the overall Medicaid Program that may be attained through prompt claim filing.
- Providers for which there is not sufficient manpower to be contacted personally by visit or by telephone should be contacted through a bulletin or letter. In this communication each provider should be made aware of his claim filing record, as well as the average time to file of his peer group. This filing comparison should be of considerable interest to many providers who are unaware of the clerical delays occurring in their offices.

RUN DATE 6/30/72
MONTH OF 4/72 THRU 6/72

PROVIDER CLAIM FILING DETAILS

CATEGORY OF SERVICE	PROVIDER NUMBER	AVERAGE DAYS TO FILING	CLAIMS RECEIVED IN 1-30 DAYS NUMBER CLAIMS	1-30 DAYS $ PAID	31-60 DAYS NUMBER CLAIMS	31-60 DAYS $ PAID	61-90 DAYS NUMBER CLAIMS	61-90 DAYS $ PAID	4-6 MONTHS NUMBER CLAIMS	4-6 MONTHS $ PAID	MORE THAN 6 MO NUMBER CLAIMS	MORE THAN 6 MO $ PAID
PHYSICIAN	1234567	41	48	618	40	480	20	183	1	14	2	32
	2345678	38	24	260	10	99	9	103	2	21		
	3456789	33	92	1,004	70	578	16	208	1	9		
	1063425	26	214	2,322	96	820	13	180			1	64
	5386621	22	165	1,542	38	216	4	39				
			(16.01)	(16.02)	(16.03)	(16.04)						

3.17.6 REPORT ITEM DESCRIPTION

PROVIDER CLAIM FILING DETAILS

Item Number	Item Name and Description
16.Ø1	PROVIDER NUMBER
16.Ø2	AVERAGE DAYS TO FILING - The average number of days from the date of service on a claim to the date the claim was received by the claims processing agency for the claims filed by the provider during the period of time covered by the report.
16.Ø3	NUMBER OF CLAIMS RECEIVED IN 1-30 DAYS, 31-6Ø DAYS, 61-9Ø DAYS, 4-6 MONTHS, MORE THAN 6 MONTHS - The number of claims received by the claims processing agency in the time intervals listed. The measurement begins with the last date of service on the claim.
16.Ø4	DOLLARS PAID - The amount paid by Title XIX for claims shown in the time intervals listed in report item 16.Ø3.

3.18 THIRD PARTY PAYMENT ANALYSIS

3.18.1 REPORT CHARACTERISTICS

MMIS Output Number:	MR-O-17
Distribution:	Provider Relations
Frequency:	Semi-Annual
Glossary Terms:	Crossover Claims Third Party

Relationship to Other MARS Reports

The Third Party Payment Analysis provides third party payment information on selected providers. The Provider Participation Analysis (MR-O-12) contains summary information on third party payments for all providers in both the current and previous time periods.

3.18.2 REPORT PURPOSE

The purpose of the Third Party Payment Analysis is to provide information on individual provider experience in the detection and subsequent collection of third party payments for Medicaid recipients. This report can be used by provider relations personnel to identify those providers who appear lax in their obligation to collect third party resources prior to making a claim on Title XIX funds. Identification is accomplished by establishing for each provider the percent of Medicaid claims that contain third party payment and then ranking providers on that percentage. Providers showing the lowest percentage are candidates for improvement in their third party collection efforts.

3.18.3 REPORT ORGANIZATION

The Third Party Payment Analysis presents, for the categories of service that have significant third party collections, the providers indicating the lowest third party participation on their Medicaid claims. Hospitals and

practitioners in particular are provider types whose third party collections should be examined through this report. Physicians are separated by practice specialty so that a physician's record of collections is compared only with physicians in similar practice. Other categories of service, such as pharmacy and ambulance, will usually have third party involvement too infrequently to warrant preparation of this report and justify the necessary follow-up.

It should be expected that physicians in certain practice specialties will experience greater third party participation on their Medicaid claims than physicians in other specialties. This is primarily caused by the variance in coverage policies of the third party carriers. For example, services of a dermatologist may not be covered by a third party carrier as often as services performed by a general practitioner. Another factor that may influence third party participation is accidents, which are frequently covered by a third party such as workman's compensation. Physicians whose practice often involves treatment of accident victims could reasonably be expected to have greater third party involvement than physicians that treat accident victims only infrequently.

Sequence	Category of Service
	Physician Specialty (if category of service is physician services)
	Percent with Third Party Payment (descending order)

Exclusions and Limitations

- Providers with a low volume of Medicaid claims should be excluded from this report.
- The number of providers appearing on the report can be limited by exercising a report option that will prevent printing those providers whose third party

collections are satisfactory. A logical procedure would be to print only those providers whose percent of claims with third party payment is less than the average percent of claims with third party payment for all providers in that category of service.

- In this report, Medicare crossover claim payments are not considered to be third party payments and payments for Medicare deductibles and coinsurance are not included in the provider payment figures.

Suggested Totals and Summaries

Significant totals are displayed on the Provider Participation Analysis (MR-O-12) report.

3.18.4 REVIEW PROCEDURES

General

The major task in the review and analysis process - identification of providers with less than average third party participation - is accomplished through preparation of the report since the report is sequenced on the percent of third party participation. Providers whose third party collections are less than the average collections of their peers should be made aware of their third party collection responsibilities under Title XIX Program regulations through appropriate communications.

Suggested Action

- Review instructions to providers concerning third party participation to insure that Medicaid policy has been adequately stated.
- Select the high volume providers appearing on the report and visit as many as possible to review their third party clerical procedures and suggest improved techniques.

- Write or telephone the remaining providers on the report encouraging them to be more vigilant in their identification and follow-up on third party responsibility involving services rendered for Title XIX recipients.

RUN DATE 6/30/72

MONTH 1/72 THRU 6/72

THIRD PARTY PAYMENT ANALYSIS

CATEGORY OF SERVICE : PHYSICIAN SERVICES PHYSICIAN SPECIALTY: GENERAL SURGERY

AVG. PERCENT OF CLAIMS WITH THIRD PARTY PAYMENT PER PROVIDER : 17.2 (17.01)

PROVIDER NUMBER	NUMBER OF CLAIMS	NUMBER WITH THIRD PARTY PAYMENT	PERCENT WITH THIRD PARTY PAYMENT	TOTAL CLAIM DOLLARS	THIRD PARTY DOLLARS	THIRD PARTY DOLLARS AS A PERCENT OF TOTAL CLAIM DOLLARS
5234567	603	55	9.1	6,356	597	9.4
5545678	1,182	108	9.1	12,671	1,406	11.1
5456789	528	49	9.2	5,507	677	12.3
5678901	441	41	9.4	4,635	413	8.9
5567890	827	79	9.5	8,973	942	10.5
(17.02)	(17.03)	(17.04)	(17.05)	(17.06)	(17.07)	(17.08)

3.18.6 REPORT ITEM DESCRIPTION

THIRD PARTY PAYMENT ANALYSIS

Item Number	Item Name and Description
17.Ø1	AVERAGE PERCENT OF CLAIMS WITH THIRD PARTY PAYMENT PER PROVIDER - The percent of claims containing third party payment is computed for each provider. The average of that percent for all providers within the category of service is shown.
17.Ø2	PROVIDER NUMBER - Only providers which do not reach a selected percent of third party payment and whose Medicaid payments exceed a minimum level are listed.
17.Ø3	NUMBER OF CLAIMS - The total number of claims filed in the six month period.
17.Ø4	NUMBER WITH THIRD PARTY PAYMENT - The number of claims containing payment from a third party.
17.Ø5	PERCENT WITH THIRD PARTY PAYMENT - The number of claims containing payment from a third party as a percent of the total number of claims filed (17.Ø4 ÷ 17.Ø3 x 1ØØ).
17.Ø6	TOTAL CLAIM DOLLARS - The total amount claimed by the provider as reimbursement for services rendered to recipients for all claims submitted.
17.Ø7	THIRD PARTY DOLLARS - The total amount of third party payments reported by the provider on all claims submitted.
17.Ø8	THIRD PARTY DOLLARS AS A PERCENT OF TOTAL CLAIM DOLLARS - Third Party Dollars as a per cent of Total Claim Dollars (17.Ø7 ÷ 17.Ø6 x 100).

3.19 PROVIDER RANKING LIST

3.19.1 REPORT CHARACTERISTICS

MMIS Output Number: MR-O-19

Distribution: Administrative
Provider Relations

Frequency: Annual

Relationship to Other MARS Reports

The Provider Ranking List provides claim payment statistics for the most active Medicaid providers. The Provider Participation Summary (MR-O-12) presents more extensive information concerning provider payments by individual category of service.

3.19.2 REPORT PURPOSE

The purpose of the Provider Ranking List is to identify the providers in each category of service that are receiving the largest payments for Medicaid services rendered. In some states, the law requires the annual publication of an official list of all providers that receive Medicaid payments in excess of a specified amount and other states find a repeated need for such information to answer legislative inqueries.

3.19.3 REPORT ORGANIZATION

General

The Provider Ranking List presents the providers that received the largest Medicaid payments in a given fiscal year. The relative position, or rank, within each category of service is shown for each provider. The ranking is based on payment amount. The number of claims, the average payment, and the percentage that provider's claims represent of all claims paid in that category of service are also shown for each provider that appears on the report.

Sequence — Category of Service
Total Payment Amount (descending order)

Exclusions and Limitations

This report might be made to contain only those practitioners and pharmacies that exceed a predetermined payment amount. For example, a cut-off point for practitioners might be established at twenty-five thousand dollars. In other categories of service, particularly institutions, all of the providers may be listed.

Other Considerations

Some Medicaid Programs prepare two versions of this report. The second version has the same format as the Provider Ranking List, but the providers are listed in provider number order and all providers are shown. The report is used as a reference document to answer inqueries concerning Medicaid payments to any provider.

3.19.4 REVIEW PROCEDURES

The Provider Ranking List is designed to identify the providers in each category of service receiving the largest Medicaid payments. Appearance on this list does not automatically indicate that a provider is abusing the Medicaid Program. Inclusion on the list could be the natural result of lack of competition or because of the type of neighborhood in which the provider is located. Therefore, there are no suggested actions for this report. However, individual Medicaid Programs may use the report to initiate certain actions based on their Program regulations. An example of this type might be a State policy that requires an audit of of all physicians receiving more than $25,000 annually from Title XIX.

RUN DATE 6/30/72
MONTH 7/71 THRU 6/72

PROVIDER RANKING LIST

CATEGORY OF SERVICE	PROVIDER NUMBER	PROVIDER NAME	NUMBER CLAIMS	PERCENT OF CATEGORY CLAIMS	PAYMENT	PERCENT OF CATEGORY PAYMENT	AVERAGE PAYMENT	RANK BY PAYMENT
PHYSICIAN	5876302	JONES H C MD	6,785	1.11	115,420	1.61	17.01	1
	5238694	SMITH J P MD	8,570	1.41	109,611	1.53	12.79	2
	5689432	BROWN R C MD	7,608	1.25	90,917	1.27	11.95	3
	5864892	THOMAS H T MD	4,989	.82	80,175	1.12	16.07	4
	(19.01)	(19.02)	(19.03)	(19.04)	(19.05)	(19.06)	(19.07)	(19.08)

3.19.6 REPORT ITEM DESCRIPTION

PROVIDER RANKING LIST

Item Number	Item Name and Description
19.Ø1	PROVIDER NUMBER
19.Ø2	PROVIDER NAME
19.Ø3	NUMBER OF CLAIMS - The number of Medicaid claims paid during the year for the provider indicated.
19.Ø4	PERCENT OF CATEGORY CLAIMS - Each provider's total number of claims expressed as a percentage of the total number of all claims paid in this category of service.
19.Ø5	PAYMENT - The amount received from Medicaid during the year by the provider indicated.
19.Ø6	PERCENT OF CATEGORY PAYMENT - Each provider's total amount paid expressed as a percentage of the total amount paid to all providers in this category of service.
19.Ø7	AVERAGE PAYMENT - The average amount paid per claim for the provider indicated.
19.Ø8	RANK BY PAYMENT - The provider's ranking within this category of service, based on total Medicaid payments received.

3.20 1099-MED

3.20.1 REPORT CHARACTERISTICS

MMIS Output Number: MR-0-20

Distribution: Provider Relations

Frequency: Yearly

Relationship to Other MARS Reports

The quarterly report, Provider Ranking List (MR-0-19), is a more detailed report designed for State use, rather than for Federal reporting.

3.20.2 REPORT PURPOSE

This output complies with Federal Internal Revenue service requirements that the total payment made to providers of medical services be reported. One 1099 is prepared for each provider who has received Medicaid payments of $600.00 or more during the reporting year. (IRS prefers that these returns be filed in magnetic tape form. For further information regarding submittal by magnetic tape contact the Director of any Internal Revenue Service Center.)

1 0 9 9 - M E D

PROVIDER NUMBER	PROVIDER NAME	SOCIAL SECURITY NUMBER	EMPLOYER IDENTIFICATION NUMBER	TOTAL ANNUAL TITLE XIX PAYMENTS
1234567	DAVIS, JOHN M.D.	039-24-0303		$15,721
(20.01)	(20.02)	(20.03)	(20.04)	(20.05)

3.20.6 REPORT ITEM DESCRIPTION

1099 MED

Item Number	Item Name and Description
20.01	PROVIDER NUMBER
20.02	PROVIDER NAME
20.03	SOCIAL SECURITY NUMBER - The account number assigned to individuals by the Social Security Administration.
20.04	EMPLOYER IDENTIFICATION NUMBER - The number assigned to employer by the Internal Revenue Service for tax reporting purposes. This number is shown in lieu of the Social Security Number if the employer is an institution or business firm.
20.05	TOTAL ANNUAL TITLE XIX PAYMENTS - The total reimbursement by Medicaid, for all categories of service, during the calendar year covered by the report.

3.21 DRUG USAGE FREQUENCY ANALYSIS

3.21.1 REPORT CHARACTERISTICS

MMIS Output Number:	MR-0-21
Distribution:	Provider Relations
Frequency:	Yearly
Glossary Terms:	Therapeutic Classification Drug Code

Relationship to Other MARS Reports

The Drug Usage by Eligibility Classification (MR-0-26), another yearly report pertaining specifically to drugs, complements this report.

3.21.2 REPORT PURPOSE

This yearly report is intended to assist in program planning and control by presenting drug data pertaining to usage and expenditure.

3.21.3 REPORT ORGANIZATION

This report presents data on the usage of drugs by Medicaid recipients during the past year. The data is in sequence by therapeutic classification, listing each drug code within that class. The report compares each drug, by cost and by number of prescriptions, with other drugs in the same class and with all drugs. It also shows the average quantity dispensed, amount paid and the average payment.

Sequence	Therapeutic Drug Class

Suggested Totals and Summaries

Though not in the general systems design, we suggest that for each class of drugs, there be a summary row of figures to show the relation of that class to all drugs. In addition, a summary row for all drugs should appear at the bottom of the report.

Other Considerations

As an option, a State may choose to print out the name of each drug next to the drug code.

If the sample report appears to have too many columns for easy review, a State may choose to have two listings instead: one that includes the data pertaining to "% of all drugs" and the other to "% of this class."

3.21.4 REVIEW PROCEDURES

General

When reviewing this report, note the relationship of each drug to other drugs within the same therapeutic class and to all drugs (intra-class and inter-class). Particularly look at those drugs which rank high in number and/or payments; are they cost effective?

Suggested Action

- For those drugs that rank high in usage and/or cost determine if there are other equally effective drugs, perhaps over-the-counter, available at lower cost.

- As a result of your analysis, you may want to 1) delete certain drugs from the formulary, 2) require prior authorization for some drugs, 3) place other limits such as only two prescriptions a month per eligible recipient or prescriptions not exceeding a certain dollar value per month per recipient.

- Refer to Drug Usage by Eligibility Classification Report (MR-O-26) to see what recipients might be most affected by new restrictions on your drug program.

- This report may provide some insight into the use of narcotics by the recipient population. For further detail on possible drug abuse, refer to the following S/UR reports:

  A. Management Summary
     1. Recipient Class Profiles
     2. Prescribed Drugs Class Profiles
     3. Physician Class Profiles
     4. Physician Treatment Analysis Class Profiles

  B. Summary Profile Reports
     1. Recipient
     2. Prescribed Drugs
     3. Physician Services

  C. Treatment Analysis Reports: Physician Services

D R U G U S A G E F R E Q U E N C Y A N A L Y S I S

THERAPEUTIC CLASS	DRUG CODE	*******NUMBER OF PRESCRIPTIONS******* TOTAL	PERCENT OF ALL DRUGS	PERCENT OF DRUG CLASS	AVG. QNT. DISPENSED	*********TOTAL AMOUNT PAID********** AMOUNT	PERCENT OF ALL DRUGS	PERCENT OF DRUG CLASS	AVERAGE PAYMENT	**********USAGE RANK BY********** *TOTAL ALL DRUGS* NUMBER	PAYMENT	*****CLASS***** NUMBER	PAYMENT
01	1246010	1,232	.2%	52.0%	32	$ 5,231	.2%	42.2%	$ 4.25	46	203	1	2
	1246143	1,142	.6%	49.0%	41	$ 6,831	.1%	55.0%	$ 5.98	81	196	2	1
	2614369	8	1.0%	.3%	16	$ 320	.1%	3.0%	$40.00	126	223	3	3
CLASS TOTAL		2,382	1.1%			$12,382	.03%		$16.74				
(21.01)	(21.02)	(21.03)	(21.04)	(21.05)	(21.06)	(21.07)	(21.08)	(21.09)	(21.10)	(21.11)	(21.12)	(21.13)	(21.14)
ALL DRUG TOTALS		16,314				$62,321			$26.14				
CLASS SUMMARY													
01		2,382				$12,382			$16.74	1	2		
02		1,163				$14,238			$20.63	2	1		

3.21.6 REPORT ITEM DESCRIPTION

DRUG USAGE FREQUENCY ANALYSIS

Item Number	Item Name and Description
21.01	THERAPEUTIC CLASS - A code assigned to each drug so that drugs may be grouped by therapeutic qualities.
21.02	DRUG CODE - A code assigned to each drug to facilitate identification and manipulation within the computer system.
21.03	TOTAL NUMBER OF PRESCRIPTIONS
21.04	NUMBER OF PRESCRIPTIONS AS A PERCENT OF ALL DRUGS - The number of prescriptions for each drug divided by the total number of prescriptions for all drugs regardless of their therapeutic classification.
21.05	NUMBER OF PRESCRIPTIONS AS A PERCENT OF DRUG CLASS - The number of prescriptions for each drug divided by the total number of prescriptions for all drugs in the same therapeutic classification.
21.06	AVERAGE QUANTITY DISPENSED - The total quantity units dispensed divided by the number of prescriptions for that drug. The definition of a quantity unit varies from drug to drug. Examples of quantity units are pills, ounces, capsules, and tubes.
21.07	TOTAL AMOUNT PAID - The total expenditure by Medicaid for each drug.

Item Number	Item Name and Description
21.08	TOTAL AMOUNT PAID AS A PERCENT OF ALL DRUGS - The Medicaid expenditure for each drug divided by the total expenditure for all drugs, regardless of therapeutic classification.
21.09	TOTAL AMOUNT PAID AS A PERCENT OF DRUG CLASS - The Medicaid expenditure for each drug divided by the total expenditure for all drugs in the same therapeutic classification.
21.10	AVERAGE PAYMENT - The Medicaid expenditure for each drug divided by the number of prescriptions for that drug. (21.07 ÷ 21.03)
21.11	USAGE RANK BY NUMBER OF PRESCRIPTIONS FOR ALL DRUGS - The relative position of each drug, based on number of prescriptions, to all drugs regardless of therapeutic classification.
21.12	USAGE RANK BY PAYMENT FOR ALL DRUGS - The relative position of each drug, based on Medicaid expenditure, to all drugs regardless of therapeutic classification.
21.13	USAGE RANK WITHIN THE SAME THERAPEUTIC CLASSIFICATION, BASED ON NUMBER OF PRESCRIPTIONS - The relative position of each drug, based on number of prescriptions, to all drugs within the same therapeutic classification.
21.14	USAGE RANK WITHIN THE SAME THERAPEUTIC CLASSIFICATION, BASED ON TOTAL PAYMENT - The relative position of each drug, based on Medicaid expenditure, to all drugs within the same therapeutic classification.

RECIPIENT RELATIONS AREA

Report Number	Report Name	MMIS Output #	Report Level
3.22	Recipient Participation Summary	MR-O-22	Level 2
3.23	County Participation Analysis	MR-O-23	Level 3
3.24	County Expenditure Analysis	MR-O-24	Level 3
3.25	Benefit Usage Analysis	MR-O-25	Level 3
3.26	Drug Usage By Eligibility Classification	MR-O-26	Level 3

3.22 RECIPIENT PARTICIPATION SUMMARY

3.22.1 REPORT CHARACTERISTICS

MMIS Output Number:	MR-O-22
Distribution:	Administration Recipient Relations
Frequency:	Monthly
Glossary Terms:	Medicaid Certification

Relationship to Other MARS Reports

The Recipient Participation Summary is supported by the County Participation Analysis (MR-O-23) and the County Expenditure Analysis (MR-O-24).

3.22.2 REPORT PURPOSE

The purpose of the Recipient Participation Summary is to present an overview of the extent to which the eligible recipient population takes advantage of the benefits available thru the Medicaid Program. Information on the number of recipients participating in the Program and the amount of payments made on their behalf is furnished for both the current and select previous time periods. A trend indicator is shown for each report item as an aid in determining the magnitude of change in that item between the current and previous time periods.

3.22.3 REPORT ORGANIZATION

General

The organization of the Recipient Participation Summary provides for a presentation of key information items by the major Title XIX aid categories (OAA, AB, APTD, and AFDC). Recipient counts and expenditure data should reflect the activity of both the categorically needy and the medically needy, when the latter group is covered by the State Plan.

Payments for Medicare deductibles and coinsurance are included in the payment totals shown on this report.

Sequence — Aid Category

Suggested Totals and Summaries

A summary page, containing the same information items that are shown for each aid category, should be calculated for all aid categories combined. Such a summary page will provide a comprehensive picture of overall Medicaid Program recipient participation.

Other Considerations

An alternative format for the Recipient Participation Summary Report is to present all report items in terms of the eligibility classifications and aid categories used in the County Participation Analysis (MR-O-23) and the County Expenditure Analysis (MR-O-24). The desirability of producing the report at this expanded level of detail is dependent on Program size and characteristics and the individual preference of Program management.

3.22.4 REVIEW PROCEDURES

General

The review process should begin with the summary page that presents information for all aid categories combined. The trend column should be examined for any indication of a significant change taking place. Comparisons of the current month data to the same month last year and the six month average will facilitate determination of the magnitude of the change and whether or not the change can be explained by seasonal variations. The remainder of the report will indicate if the change in the summary report item values is attributable to recipient activity confined to one particular aid category.

Suggested Action

- The percent of eligible recipients participating in the Program should be monitored to alert management to any significant percentage shift in Program usage. A decrease in this percentage could indicate that newly enrolled recipients are not being informed of services that can be obtained under the Program. Recipient awareness of Program benefits can be increased through the use of informational pamphlets mailed with the monthly grant and through verbal communication by the social workers.
- Another possible cause for decreasing recipient participation in the Program could be a decline in the number of participating providers, thus making it difficult for recipients to obtain medical care. The extent of participation of providers can be determined from the Provider Participation Analysis (MR-O-12), which monitors provider activity within the Medicaid Program.
- The average days from date of application to date of Medicaid certification (report item 22.07) is a measurement of the efficiency of the eligibility certification process. Any marked increase in the average number of days required for certification should initiate an inquiry to the responsible department as to the cause for the delay. Even though Title XIX eligibility certification will be retroactive back to the recipient's date of application, applicants often experience great difficulty in obtaining needed medical services during the period required by the State to determine eligibility and issue proper eligibility identification.

RUN DATE 6/30/72

MONTH OF 6/72

RECIPIENT PARTICIPATION SUMMARY

AID CATEGORY		THIS MONTH	SAME MONTH LAST YEAR	SIX MONTH AVG. THIS YEAR	TREND	FISCAL YEAR-TO-DATE THIS YEAR	FISCAL YEAR-TO-DATE LAST YEAR
OAA							
NUMBER OF ELIGIBLE RECIPIENTS	(22.01)	72,360	71,420	72,104	+.001	76,072	75,541
NUMBER OF ELIGIBLE RECIPIENTS PARTICIPATING	(22.02)	41,610	40,812	40,962	+.001	66,989	63,590
PERCENT PARTICIPATING	(22.03)	57.5 %	57.1 %	56.8 %	+.001	88.1 %	84.2 %
NUMBER OF MEDICALLY NEEDY PARTICIPATING	(22.04)	1,480	1,004	1,360	+.001	3,460	3,140
TOTAL TITLE XIX PAYMENTS	(22.05)	1,828,698	1,638,169	1,801,422	+.002	16,479,287	15,399,962
AVG. PAYMENT PER ELIG RECIP	(22.06)	43.95	40.14	43.98	+.000	246.00	234.20
AVG. DAYS FROM DATE OF APPLICATION TO MEDICAID CERTIFICATION	(22.07)	16	20	17	-.001	16	19

3.22.6 REPORT ITEM DESCRIPTION

RECIPIENT PARTICIPATION SUMMARY

Item Number	Item Name and Description
22.Ø1	NUMBER OF ELIGIBLE RECIPIENTS - An unduplicated count of the number of recipients eligible for Medicaid during the time period shown.
22.Ø2	NUMBER OF ELIGIBLE RECIPIENTS PARTICIPATING - An unduplicated count of the number of eligible recipients receiving Medicaid benefits during the time period shown.
22.Ø3	PERCENT PARTICIPATING - The percent of eligible recipients that received Medicaid benefits during the time period shown (22.Ø2 ÷ 22.Ø1 x 1ØØ).
22.Ø4	NUMBER OF MEDICALLY NEEDY PARTICIPATING - The number of medically needy participants receiving Medicaid benefits that would have qualified for the aid category shown had their incomes been lower.
22.Ø5	TOTAL TITLE XIX PAYMENTS - The total Medicaid expenditures for categorically and medically needy recipients in the aid category shown.
22.Ø6	AVERAGE PAYMENT PER ELIGIBLE RECIPIENT - The average Medicaid expenditure per participating recipient (22.Ø5 ÷ 22.Ø2).

Item Number	Item Name and Description
22.Ø7	AVERAGE DAYS FROM DATE OF APPLICATION TO MEDICAID CERTIFICATION - The average elapsed days from the date of application for Medicaid benefits to the date eligibility certification is recorded on the Medicaid eligibility records for the recipients added to the eligibility roles during the time period shown.

3.23 COUNTY PARTICIPATION ANALYSIS

3.23.1 REPORT CHARACTERISTICS

MMIS Output Number: MR-O-23

Distribution: Recipient Relations
County Offices

Frequency: Monthly

Relationship to Other MARS Reports

The County Participation Analysis provides supporting detail to the Recipient Participation Summary (MR-O-22) and compliments the Expenditure Analysis (MR-O-Ø4).

3.23.2 REPORT PURPOSE

The purpose of the County Participation Analysis is to enable Program management and county supervisory personnel to determine the extent of Medicaid participation in each county. This report should be of particular value in identifying geographical areas where the recipient population does not or can not avail itself of Title XIX medical services.

3.23.3 REPORT ORGANIZATION

General

The County Participation Analysis presents, by individual county, information on recipient participation and the resulting Medicaid payments for each aid category within recipient eligibility classifications of categorically needy - receiving money payment, categorically needy - not receiving money payment, and medically needy. The section containing data on the medically needy is, of course, not required in those states that do not provide benefits for the medically needy. The aid categories shown on the sample report are the same categories specified on the Federal report SRS-NCSS-2082.

Sequence County Code

Suggested Totals and Summaries

A total page, in the same format as shown for each county, should be produced for all counties combined.

3.23.4 REVIEW PROCEDURES

General

At the State level, review of the County Participation Analysis is best accomplished through comparison of the overall county participation percentage to the state-wide percentage of eligible recipients that are participating in the Program. Through this approach, individual counties can be identified that have a low rate of recipient participation. Instances of low participation could be the result of inadequate education of the recipient population or insufficient participation on the part of the providers in that county.

At the individual county level the supervisor of welfare services can use the report to determine where recipients in a particular aid category are not obtaining services at the average level indicated by the state-wide summary.

Suggested Action

- If the suspected cause of poor recipient participation is a reluctance on the part of providers to participate in the Medicaid Program, providers in the area can be personally contacted and encouraged to provide medical services to Medicaid recipients. If provider discontent with the Program is deep-rooted and widespread, then the seriousness of the problem may warrant a review at the policy making or legislative level. For instance, physician relations may have deteriorated to the point that only the payment of a higher percentage of

allowable physician charges will succeed in increasing physician Program participation.

- Lack of recipient awareness of the benefits available through the Medicaid Program is another possible explanation for a low level of recipient participation. This situation can best be remedied at the local county level through an educational campaign conducted by the county social workers.
- Another reason for low utilization of benefits in rural areas is the absense of adequate transportation facilities to provide recipients with access to medical services only available in the more urban areas. Many Programs have alleviated the transportation problem by obtaining direct assistance from local welfare offices, utilizing volunteer community organizations, and by expanding the Medicaid Program transportation coverage.

RUN DATE 6/30/72

MONTH OF 6/72

COUNTY PARTICIPATION ANALYSIS

COUNTY: FRANKLIN	ELIGIBLE RECIPIENTS	PARTICIPATING RECIPIENTS	PERCENT PARTICIPATING	PAYMENT PER ELIGIBLE RECIPIENT
CATEGORICALLY NEEDY (MONEY PAYMENT)				
OAA	4,404	3,511	79.7 %	36.40
AB	103	76	73.8 %	37.67
APTD	1,734	1,225	70.6 %	33.78
AFDC CHILDREN	2,416	821	34.0 %	14.46
AFDC ADULTS	17	15	88.2 %	93.06
TOTAL	8,674	5,648	65.1 %	29.89
CATEGORICALLY NEEDY (NO MONEY PAYMENT)				
OAA	199	181	91.0 %	322.14
AB	1	1	100.0 %	.13
APTD	21	14	66.7 %	191.10
AFDC CHILDREN	154	57	37.0 %	21.97
AFDC ADULTS	1,345	1,065	79.2 %	24.76
OTHER XIX CHILDREN	8	4	50.0 %	48.63
TOTAL	1,728	1,322	76.5 %	60.88
MEDICALLY NEEDY				
OAA-RELATED	132	128	97.0 %	52.84
AB-RELATED	3	0	.0 %	.00
APTD-RELATED	51	45	88.2 %	42.55
AFDC-RELATED CHILDREN	80	56	70.0 %	25.00
AFDC-RELATED ADULTS	15	11	73.3 %	9.47
OTHER XIX CHILDREN UNDER 21	8	0	.0 %	.00
OTHER XIX ADULTS 21-64	5	0	.0 %	.00
TOTAL	294	240	81.6 %	38.36
TOTAL RECIPIENTS	10,696	7,210	67.4 %	35.13
OTHER RECIPIENTS				
	(23.01)	(23.02)	(23.03)	(23.04)

3.23.6 REPORT ITEM DESCRIPTION

COUNTY PARTICIPATION ANALYSIS

Item Number	Item Name and Description
23.Ø1	ELIGIBLE RECIPIENTS - An unduplicated count of the number of recipients in the county eligible for Medicaid during the month in the aid category indicated.
23.Ø2	PARTICIPATING RECIPIENTS - An unduplicated count of the number of recipients in the county receiving one or more units of Medicaid service during the month.
23.Ø3	PERCENT PARTICIPATING - The number of recipients participating expressed as a percent of the number of eligible recipients.
23.Ø4	PAYMENT PER ELIGIBLE RECIPIENT - The total of all payments made on behalf of participating recipients divided by the number of eligible recipients.

3.24 COUNTY EXPENDITURE ANALYSIS

3.24.1 REPORT CHARACTERISTICS

MMIS Output Number: MR-O-24

Distribution: Administration
Recipient Relations
County Offices

Frequency: Monthly

Relationship to Other MARS Reports

The County Expenditure Analysis complements the County Participation Analysis (MR-O-23). Both reports provide information on an individual county basis, the former concerned primarily with what type of service is used by participating recipients - the latter more concerned with the extent to which recipients in the county are participating.

3.24.2 REPORT PURPOSE

The County Expenditure Analysis is designed to provide a breakout for a county showing where the expenditures are going that are made on behalf of the recipients in that county. Such expenditure information on the county Medicaid recipient population should prove valuable in answering inqueries from State legislators and various county officials. In States where counties bear some portion of the State Medicaid Program cost, the Expenditure Analysis will be useful in calculating and substantiating the monies due from the respective counties.

3.24.3 REPORT ORGANIZATION

General

The County Expenditure Analysis shows on an individual county basis both the volume of claims submitted and the resulting dollars paid for the various classifications of

recipient eligibility. The recipient eligibility classifications shown are the categorically needy (both recipients receiving money payment and those who do not) and the medically needy. Individual aid categories, e.g., OAA and APTD, are designated under each of the recipient eligibility classifications. Expenditure data for these recipient groups is presented in terms of claims and payments for the major categories of service as well as the Program as a whole.

Sequence County Code

Suggested Totals and Summaries

Totals should be formed for each individual county and then combined to show expenditure results for the State as a whole.

3.24.4 REVIEW PROCEDURES

The County Expenditure Analysis is primarily an information report, i.e., a report designed to provide data on an "as called for" basis as opposed to an exception report designed to cope with a specific problem. Experience has shown that recipient expenditure data on an individual county basis can be of great value in informing and educating local and State politicians concerning the impact of the Medicaid Program on their respective constituency. The County Expenditure Analysis can also be used by the State Agency as a statement of services rendered to the recipients of a particular county when the State Plan calls for a joint County/State sharing of the State portion of the total Medicaid Program cost.

COUNTY EXPENDITURE ANALYSIS

COUNTY: FRANKLIN

	INPATIENT		PHYSICIAN		NURSING HOME		PHARMACY		OTHER		TOTAL	
	CLAIMS	DOLLARS	CLAIMS	DOLLARS	CLAIMS	DOLLARS	CLAIMS	DOLLARS	CLAIMS	DOLLARS	CLAIMS	DOLLARS
CATEGORICALLY NEEDY (MONEY PAYMENT)												
OAA	117	29,073	1,715	28,542	203	65,231	8,168	31,433	379	6,028	10,582	160,307
AB	4	1,186	70	1,165			333	1,283	15	246	422	3,880
APTD	73	17,215	1,074	17,882			5,117	19,694	237	3,777	6,501	58,568
AFDC CHILDREN	43	10,679	630	10,485			3,000	11,547	139	2,214	3,812	34,925
AFDC ADULTS	2	1,180	11	170			52	194	5	38	70	1,582
TOTAL	239	59,333	3,500	58,244	203	65,231	16,670	64,151	775	12,303	21,387	259,262
CATEGORICALLY NEEDY (NO MONEY PAYMENT)												
OAA	67	11,508	678	11,298	82	26,470	3,233	12,443	150	2,386	4,210	64,105
AB							3	13			3	13
APTD	7	1,227	72	1,205			344	1,327	16	254	439	4,013
AFDC CHILDREN	6	1,035	61	1,016			290	1,119	13	214	370	3,384
AFDC ADULTS	60	10,184	600	9,998			2,861	11,011	132	2,111	3,653	33,304
OTHER XIX CHILDREN	2	123	9	120			33	119	3	27	47	389
TOTAL	142	24,077	1,420	23,637	82	26,470	6,764	26,032	314	4,992	8,722	105,208
MEDICALLY NEEDY												
OAA-RELATED	35	1,265	75	1,242	10	2,838	356	1,367	17	263	493	6,975
AB-RELATED												
APTD-RELATED	1	370	47	778			223	857	11	165	282	2,170
AFDC-RELATED CHILDREN	26	946	28	456			131	502	6	96	191	2,000
AFDC-RELATED ADULTS			3	58			16	64	1	12	20	142
OTHER XIX CHILDREN UNDER 21												
OTHER XIX ADULTS 21-64												
TOTAL	62	2,581	153	2,534	10	2,838	726	2,790	35	536	1,016	11,279
TOTAL XIX RECIPIENTS	443	85,991	5,073	84,421	295	94,539	24,160	92,973	1,124	17,831	31,125	375,755
OTHER RECIPIENTS												
	(24.01)	(24.02)										

3.24.6 REPORT ITEM DESCRIPTION

COUNTY EXPENDITURE ANALYSIS

Item Number	Item Name and Description
24.Ø1	CLAIMS - The number of claims for the category of service and aid category indicated for which a Medicaid payment was made during the month.
24.Ø2	DOLLARS - The total amount of the Medicaid payments made during the month for the category of service and aid category indicated.

3.25 BENEFIT USAGE ANALYSIS

3.25.1 REPORT CHARACTERISTICS

MMIS Output Number: MR-O-25

Distribution: Recipient Relations

Frequency: Yearly

Glossary Terms: Aid Category, Eligible Recipient, Service Limits, Participating Recipient

Relationship to Other MARS Reports

Other related reports are: Medical Assistance Program Status (MR-O-02), Financial Summary (MR-O-03), Expenditure Analysis (MR-O-04), Provider Participation Summary (MR-O-04), and Provider Participation Analysis (MR-O-12).

3.25.2 REPORT PURPOSE

This report provides planning and control information by presenting utilization rates of recipient benefits within the framework of limits for those services which have limitations. This information is helpful in assessing the restrictions a State may have on various services especially if the State is planning to tighten or loosen controls.

3.25.3 REPORT ORGANIZATION

General

This report presents, by aid category, data pertaining to recipient participation. For each category of service, this report shows the service limits on that service, if any;

the number of eligible recipients; the number of participating recipients; the average number of service units per eligible and participating recipient; and the percent of eligible recipients utilizing within certain percentages of the maximum.

Suggested Totals and Summaries

A State may wish to include, at the bottom of this report, totals for all aid categories for those items where these totals may be meaningful.

Other Considerations

As this is an annual report, the service restrictions as listed on the report are of course annual restrictions. States that have monthly restrictions may wish either to change this report from an annual to a monthly report or to keep it an annual report but with the data broken down by month. As a matter of fact, service limits vary so much from State to State, that this report, probably more than any other, will have to be very much modified to fit each State's needs. The sample report in this volume should be considered merely a point of departure for States to use in designing their own report.

3.25.4 REVIEW PROCEDURES

General

Review the data for each type of service separately for a picture of the utilization rate for that service. Note particularly what percentages of eligible recipients are utilizing the various percentages of the maximum benefits

(report items 25.06 and 25.07). (These percentages of maximum may be varied to suit the needs of the State). Also compare the utilization rates among the various services and among the and categories.

Suggested Action

- If a significant percentage of recipients is utilizing near the maximum of one or more services these recipients might have actually needed more than the maximum benefits your program allows. Should you wish to liberalize your program, you might make the limitations on this service(s) less stringent. Limits are set as controls and if the maximum is being utilized, then the control is apparently effective; however is it working to the detriment of many recipients? Is it precluding the availability and accessibility of needed medical care?

- If the maximum allowable benefits of one or more services are being minimally used, you might wish to change the limits on that service(s) to make them more realistic. In short, this report tells you how well your controls, in this case service limits, are working and gives you valuable information to use when making decisions concerning tightening or relaxing these controls.

- A State that has services that do not have any limits may wish to fabricate some restrictions for purposes of this report to see what the utilization rate is. This would also provide useful information for those states comtemplating actually placing restrictions on their benefits.

RUN DATE 6/30/72

B E N E F I T U S A G E A N A L Y S I S

AID CATEGORY - OAA		INPATIENT	OUTPATIENT	NURSING HOMES	PHYSICIAN SERVICES	LAB AND X-RAY	PRESC. DRUGS	HOME HEALTH	PERIODIC SCREEN	OTHER
SERVICE LIMITS	(25.01)	10 DAYS	5 VISITS	365 DAYS	20 VISITS	NONE	NONE	NONE	N/A	NONE
NUMBER OF ELIGIBLE RECIPIENTS	(25.02)	41,000	41,000	41,000	41,000	41,000	41,000	41,000	N/A	41,000
NUMBER OF PARTICIPATING RECIPIENTS	(25.03)	38,400	36,700	9,540	40,610	32,000	39,700	21,600	N/A	15,300
AVG. SERVICE UNITS PER ELIGIBLE RECIPIENT	(25.04)	5.0	4.2	228	10.3	5.2	12.1	2.1	N/A	4.6
AVG. SERVICE UNITS PER PARTICIPATING RECIPIENT	(25.05)	8.0	7.1	368	14.6	9.0	14.2	6.1	N/A	9.5
PERCENT OF ELIGIBLE RECIPIENTS UTILIZING - MAXIMUM BENEFITS	(25.06)	10	8	65	46	N/A	N/A	N/A	N/A	N/A
75-99 % OF MAXIMUM	(25.07)	30	52	15	26	N/A	N/A	N/A	N/A	N/A
50-74 % OF MAXIMUM		20	30	10	18	N/A	N/A	N/A	N/A	N/A
25-49 % OF MAXIMUM		35	10	5	8	N/A	N/A	N/A	N/A	N/A
0-24 % OF MAXIMUM		5	0	5	2	N/A	N/A	N/A	N/A	N/A

3.25.6 REPORT ITEM DESCRIPTION

BENEFIT USAGE ANALYSIS

Item Number	Item Name and Description
25.01	SERVICE LIMITS - The restrictions on utilization of benefits that may be applied by a State Medicaid Program. For example, a recipient might be limited to ten inpatient days of stay per year.
25.02	NUMBER OF ELIGIBLE RECIPIENTS - An unduplicated count of the number of recipients eligible for Medicaid benefits in the time period covered by the report.
25.03	NUMBER OF PARTICIPATING RECIPIENTS - An unduplicated count of the number of recipients receiving Medicaid benefits in the time period covered by the report.
25.04	AVERAGE SERVICE UNITS PER ELIGIBLE RECIPIENT - The total units of service provided in each category divided by the number of eligible recipients.
25.05	AVERAGE SERVICES/PARTICIPATING RECIPIENTS - The total units of service provided in each category divided by the number of recipients receiving benefits.
25.06	PERCENT OF ELIGIBLE RECIPIENTS UTILIZING MAXIMUM BENEFITS - The number of recipients that received the maximum benefits available in a category of service divided by the number of eligible recipients.

Item Number	Item Name and Description
25.07	PERCENT OF ELIGIBLE RECIPIENTS UTILIZING 75-99% OF MAXIMUM, 50-74% OF MAXIMUM, 25-49% OF MAXIMUM, 0-24% OF MAXIMUM. The number of recipients receiving benefits in each of the ranges shown above are accumulated. For example, recipients receiving 16-19 physician visits, upon which there is a 20 visit maximum, would be counted as receiving 75-99% of maximum available benefits. The number of recipients counted in each range is divided by the number of eligible recipients to obtain the value of the report item.

3.26 DRUG USAGE BY ELIGIBILITY CLASSIFICATION

3.26.1 REPORT CHARACTERISTICS

MMIS Output Number:	MR-O-26
Distribution:	Recipient Relations
Frequency:	Yearly
Glossary Terms:	Therapeutic Classification
	Aid Category

Relation to Other MARS Reports

Two other annual MARS reports that complement this report are the Drug Usage Frequency Analysis (MR-O-21) and the Benefit Usage Analysis (MR-O-25). In addition, more detailed information is contained in the S/UR Management Summary Report - Recipient Class Profiles.

3.26.2 REPORT PURPOSE

This report presents drug usage data by Aid Category and compares the number of recipients and dollar usage among categories for each Therapeutic Classification Code. The report is intended to assist program planning and control.

3.26.3 REPORT ORGANIZATION

General

For each therapeutic drug class, this report shows the following information by each Aid Category: number of recipients, dollar amount of usage and percent of usage by Aid Category.

Sequence Aid Category within therapeutic drug class.

3.26.4 REVIEW PROCEDURES

General

For each drug class compare the usage of that class by the various Aid Categories using the "percent of usage by Aid Category" figures (report item 26.05) as your prime basis for comparison. Does the relative usage of that class seem appropriately distributed among the different Aid Categories? Also review and compare the data for each drug class with the data for the other drug classes. Are certain classes being over-utilized by some Aid Categories? By the recipient population as a whole? Check also for under-utilization: do you expect certain Aid Categories to need certain classes of drugs but this report indicates they are not receiving them?

Suggested Action

- For more detailed information on drug utilization, refer to the S/UR Management Summary Report - Recipient Class Profiles.

RUN DATE 6/30/72

D R U G U S A G E B Y E L I G I B I L I T Y C L A S S I F I C A T I O N

THERAPEUTIC CLASS	AID CATEGORY	NUMBER OF RECIPIENTS	DOLLAR AMOUNT OF USAGE	PERCENT OF USAGE BY AID CATEGORY
01	OAA	24,670	82,360	22.8 %
	APTD	14,320	41,460	10.2 %
	AB	9,640	35,410	9.3 %
	AFDC	41,210	105,470	32.2 %
	MN	10,360	39,372	8.5 %
	OTHER	4,760	20,210	7.0 %
(26.01)	(26.02)	(26.03)	(26.04)	(26.05)

3.26.6 REPORT ITEM DESCRIPTION

DRUG USAGE BY ELIGIBILITY CLASSIFICATION

Item Number	Item Name and Description
26.01	THERAPEUTIC CLASS - A grouping of drugs that have similar therapeutic qualities. Examples of therapeutic classifications are antihistamines, tranquilizers, and diuretics.
26.02	AID CATEGORY
26.03	NUMBER OF RECIPIENTS - An unduplicated count of recipients, by aid category, that received one or more drugs in the therapeutic classification shown.
26.04	DOLLAR AMOUNT OF USAGE - The Medicaid expenditure, by aid category, for drugs in the therapeutic classification shown.
26.05	PERCENT OF USAGE BY AID CATEGORY - Each aid category's percent of the total Medicaid expenditure for drugs in the therapeutic classification shown.

4. CONSIDERATIONS IN USE OF THE MARS REPORTS

4. CONSIDERATIONS IN USE OF THE MARS REPORTS

4.1 INTERIM PROCEDURES UNTIL MARS MATURITY

A principal feature of the Management and Administrative Reporting System is the presentation of key information for not only the most recent time period, but for other previous time periods as well. Specifically, nineteen of the twenty-six MARS reports require claim history data in order to present a complete picture of Program progress. Most of these reports contain a trend indicator or year-to-date data for this year and last year, both of which necessitate at least twelve months of claim history. The inability to make full utilization of many of the reports in the first year of MARS system operation suggests that consideration be given to interim procedures that could be applied until the MARS reports become fully mature.

Of course, the simplest approach for dealing with the initial lack of claims history on the MARS reports is to disregard those report items whose informational value is derived from a comparison of the current data with similar data from previous time periods. However, many of the key MARS reports lose much of their value when no comparison of this type can be made. In these situations a special effort should be made to obtain the necessary historical data from other sources or through manual computations based on existing reports. For example, it might be possible to manually calculate certain previous year and year-to-date figures from various statistical reports that preceded the MARS system. Also, after several months of operation of the

MARS system, the current month's reports can be visually compared to previous months' MARS reports to ascertain the direction and magnitude of change in key report items.

An alternate approach to that of obtaining historical comparative data from existing sources is that of using some type of sampling to determine key report item values in past time periods. The use of sampling would be particularly appropriate in establishing the value of those key report items that describe the performance of the claims processing operation. For example, a random sample could be taken of last year's paid claims records to determine past experience in claim rejection rates, claim error rates, and average days required for claim approval.

The most accurate method of satisfying the MARS system need for adequate claim history is to undertake a conversion of existing machine readable claims history records into a form usable by the MARS system. Appropriate modifications could then be made to the MARS system to enable use of the system to create the required historical data base. Of course, this approach presupposes that data elements needed on the MARS reports are present in the old claim records. It should also be recognized that considerable staff effort and computer time may be required to plan and perform a data conversion of this type. Each State in giving consideration to this approach should conduct a feasibility and cost benefits analysis to determine the practicality and value of undertaking an automated conversion as compared to the inconvenience and loss in effectiveness caused by the lack of information on the MARS reports.

4.2 REPORT CONTENT CONSIDERATIONS

4.2.1 Medicare Crossover Claims

Medicare crossover claims presented to the Medicaid Program for payment of coinsurance and deductibles are a potential source of confusion in MARS reports. Since these claims do not contain certain data elements required on some of the analytical reports, inclusion of Medicare claims can distort report items that are derived through use of these missing data elements. For example, report items that reflect an accumulation of units of service might be misleading since units of service are not always readily distinguishable on typical Medicare claims.

Other possible sources of confusion concerning Medicare crossovers involve treatment of Medicare as a third party and the measurement of claim filing delays when the provider participates in Title XVIII as well as Title XIX. It is recommended that Medicare not be considered as a third party resource on those MARS reports concerned with third party collections. In any event the position taken with respect to Medicare as a third party should be consistent on all MARS reports. Medicare claims should be excluded from computations involving provider claim filing delays as Medicaid providers do not have control over the length of time the claims are in process by the Medicare carrier or intermediary.

As a general guideline, it is suggested that Medicare crossover claims be included in only the following MARS reports:

MR-O-Ø1	Medical Assitance Financial Status
MR-O-Ø2	Medical Assistance Program Status
MR-O-Ø3	Financial Summary
MR-O-Ø4	Expenditure Analysis
MR-O-Ø5	Medicare Participation Analysis
MR-O-Ø7	SRS-NCSS-2Ø82
MR-O-Ø8	Operational Performance Summary
MR-O-Ø9	Claims Processing Performance Analysis
MR-O-19	Provider Ranking List
MR-O-22	Recipient Participation Summary
MR-O-23	County Participation Analysis
MR-O-24	County Expenditure Analysis

Medicare claims should be excluded from computations that involve units of service and claim filing delays on the above reports.

4.2.2 MARS Reports in the Operations Area

The MARS reports in the Operations Area are designed to monitor the performance of a MMIS Claims Processing System. The MARS reports assume the presence of a continuously circulating suspense file for retention of claims until adjudication is complete. It is further assumed that such data as approval date and claim error codes are

retained in the claim history record. As a consequence MARS operations reports would not be applicable for use in conjunction with a claims processing system that did not utilize the same concepts and contain the same data elements as the MMIS Claims Processing System.

4.2.3 Data Projections and Trends

A fundamental precept of the MARS system is the accounting of each claim processed in accordance with the date on which that claim was paid. The basis for MARS reporting is the date of payment as contrasted with the MMIS Surveillance and Utilization Review System which operates on a date of service basis. Medicaid expenditure rates and budget comparisons become meaningful only when presented on a date paid or cash accounting basis. However, there are some potential hazards involved with use of this concept in certain aspects of MARS reporting, principally trend computations and expenditure projections.

The validity of any data trend or projection is dependent upon the base data from which the computation is made being both complete and representative. Any significant, non-recurring change in Program expenditures can easily distort Medicaid expenditure projections. For example, in order to conserve funds in a particular category of service, a temporary curtailment in prior authorization approvals might be instituted. Such action will cause a corresponding decrease in the expenditure trend

value for that category of service. A budget projection for the next fiscal year that is formulated from this trend value could well result in an understatement of the service costs that will occur in the future when the temporary restriction on prior authorizations is lifted.

In a similar manner, an across the board budget control measure that temporarily reduces all payments by a given factor, or a sharp jump in hospitalization because of some natural disaster, could produce misleading trends or projections. The important point is that the user of this type of MARS information should have a clear understanding as to how the various trends, projections, and averages are formulated so that he can make the necessary adjustments to the computed report values to remove the effects of any non-recurring change in Program activity.

4.3 MARS REPORTS THAT MAY BE OPTIONAL

There are some MARS reports that will have little or no use to the State Agency because of the particular characteristics of that State's Medicaid Program. The following reports might well fall into this category for the reasons cited below.

- Provider Claim Filing Analysis (MR-O-15) and Provider Claim Filing Details (MR-O-16) - These two reports deal principally with the identification of providers who consistently delay in filing claims after the service has been rendered. States which have established short claim filing deadlines will have less need for these reports.

- Cost Settlement Analysis (MR-O-13) - This report examines cost settled providers whose interim reimbursement is based on per diem payments, in order to evaluate the appropriateness of such interim reimbursement rates. This report would be of no value in States where the cost settled providers are reimbursed on a percent of charges as there would be no basis for comparison.

- Benefit Usage Analysis (MR-O-25) - The Benefit Usage Analysis provides a measure of the extent to which the recipient population utilizes the maximum benefits available under the State Medicaid Program. Medicaid Programs that have no benefit limitations for the various categories of service could omit this report although an analysis of the State's actual service usage experience might prove to be of value in Program planning.

- Drug Usage Analysis (MR-O-21) and Drug Usage by Eligibility Classification (MR-O-26) - These two reports are concerned with utilization of drugs available under the Program. State Medicaid Programs that do not provide for drug coverage will, of course, have no use for these reports.

4.4 EXTENDING THE USEFULNESS OF MARS REPORTS

In reviewing the performance of a Medicaid operation, it is often desirable to measure the change in key information items over a period of time. Some MARS reports portray relationships

between current and previous time periods through the use of trend indicators, monthly averages, and same month-previous year figures. A more comprehensive and understandable management technique for conveying the degree of change in value of key information is through the use of graphs.

Using graphs, the month by month values of a key report item can be plotted to obtain a pictorial representation of the movement of this data over a period of time. Trends will be easily interpreted from the slope of the line connecting the monthly values and seasonal influences should be discernable after twenty-four months' data has been plotted. Frequently, combinations of report items can be plotted on the same graph. This technique permits visual interpretation of the interaction between report items, a task which is usually more difficult when only tabular report data is available.

Graphs will be most useful in the Program Administration and Operations areas. The Medical Assistance Program Status report (MR-O-Ø2) contains several report items which the chief administrator of the Program should find useful in a graphic form. In the Operations Area, a graph or histogram can be an effective tool for measurement of various aspects of claims processing performance. For example, the average days from claim entry date to claim approval, the percent claims rejected, and the average errors per claim could be plotted for each category of service and posted on a bulletin board. In this way employees can be made aware of their performance level in a manner that will foster healthly

competition between claims processing units.

There are many additional instances where graphs will enhance user understanding. Since there are organizational differences in each Medicaid Program and since the exact content of MARS reports is not determined until the detail design phase of a MMIS implementation project, each State should take these factors into consideration in determining the extent to which graphs should be utilized to depict Program activity.

5. APPENDIX

5.1 GLOSSARY OF TERMS

Terms	Definition
Adjudicate	To determine whether a claim (credit, or adjustment) is to be paid or disallowed.
Adjustment	A transaction which has the effect of changing the payment amount, charges, and/or units of service of a previously paid claim.
Aid Category	A designation within the State Social Services Department under which a person may be eligible for public assistance and/or medical assistance.
Approved	A term used to designate a claim that has been determined payable, but has not yet been paid. This distinction can become important when the agency responsible for claims processing is different from the agency authorized to make the actual payment.
Benefits	Medical care services available under the Medicaid Program.
Budget Amount	The planned expenditures for a given time period.
Buy-In	A process whereby the State enters into an agreement with the Bureau of Health Insurance, Social Security Administration, to obtain Supplementary Medical Insurance Benefits (Medicare, Part B) for aged recipients receiving monthly payments under public assistance titles. The State pays the monthly premium for these benefits on behalf of the recipient.

Terms	Definition
Categorically Needy	All individuals receiving financial assistance under the State's approved plan under Titles I, IV-A, X, XIV, and XVI of the Social Security Act or who are in need under the State's standards for financial eligibility in such plan.
Category of Service	A designation of the nature of the service rendered (e.g., hospital outpatient, pharmacy, physician).
Charge Center	A provider accounting unit within an institution that is used to accumulate specific cost data related to medical and health services that are rendered (e.g., laboratory,tests, emergency room service, etc.).
Claim	A bill rendered by a provider to the Single State Agency for a procedure, a set of procedures, or a service rendered to a recipient for a given diagnosis or set of related diagnoses. (More than one claim may appear on certain ledger-type input forms. In this case, entries on the claim form represent separate claims, rather than line items.)
Claim Transaction	Any one of the records processed through the Claims Processing Subsystem. Examples are: 1. Claims 2. Credits 3. Adjustments 4. Queries 5. Approved Prior Authorizations

Terms	Definition
Claims Processing Agency	An agency that performs the claims processing function for Medicaid claims. The agency may be a department of the Single State Agency responsible for Title XIX or a contractor of the agency, such as a fiscal agent.
Cost Settlement	A process by which claims payments to institutional providers are adjusted yearly to reflect actual costs incurred.
Credit	A claim transaction which has the effect of reversing a previously processed claim transaction.
Crossover Claims	Claims for which both Title XVIII and XIX are liable for services rendered to a recipient entitled to benefits under both programs.
Drug Code	A code established to identify a particular drug covered by the State Medicaid Program.
Eligible Providers	A person, organization, or institution approved by the Single State Agency as eligible for participation in the State Medicaid Program.
Eligible Recipients	Individuals who have been certified as eligible for participation in the State Medicaid Program by the State Agency responsible for determination of Title XIX eligibility.
Eligibility File	A file containing individual records for all persons who are eligible or have been eligible for Medicaid.

Terms	Definition
Errors	A term used to designate those claims that are suspended at some point prior to adjudication. Several classifications of errors could exist; for example: claims with data discrepancies, or claims held up for investigation of possible third party liability. Claims placed on suspense for investigatory action can be excluded from classification as an error at the user's option during detail system design.
Error Code	A code connected to a claim transaction that indicates the nature of an error condition associated with that claim. An error code can become a rejection code if the error condition is such that the claim is rejected.
Medicaid Certification	The determination of a recipient's entitlement to Medicaid benefits and notification of that eligibility to the agency responsible for Medicaid claims processing.
Medicaid-Medicare Eligible	A recipient who is eligible for benefits under both Medicaid and Medicare. Recipients in this category are "bought-in" for Part B coverage of the Medicare Program by the Medicaid Program.
Medically Needy	Individuals whose income and resources equal or exceed those levels for assistance established under a State Plan but are insufficient to meet the costs of health and medical services.

Terms	Definition
Override	A term under to describe the forced by-passing during computer processing of an error condition in a claim. The override is initiated by the claims processing agency when a claim, exempted from payment because of a suspected error, proves under subsequent investigation not to be in error.
Participant	One who participates in the Medicaid Program as either a provider by furnishing Title XIX services or a recipient by receiving Title XIX services.
Participating Providers	Providers who furnish Title XIX services during a specified period of time.
Participating Recipients	Individuals who receive Title XIX services during a specified period of time.
Provider	A person, organization, or institution certified to provide health or medical care services authorized under a State Medicaid Program.
Provider Relations	The activity within the Single State Agency which handles all relationships with Medicaid providers.
Per Diem	A daily rate charged by institutional providers.
Recipient	One who received Medicaid services.
Recipient Relations	The activity within the Single State Agency which handles all relationships between Medicaid and individual recipients.

Terms	Definition
Reject	To return to a provider a claim which for one or more reasons is determined to be ineligible for payment.
Rejected	A term used to describe a claim that has been determined non-payable and thus returned to the provider. The provider may correct and resubmit a rejected claim so that the claim subsequently becomes payable.
Report Item	Any unit of information or data appearing on an output report.
Service Limits	The maximum number of service units to which a recipient is entitled, as established by the State Medicaid Plan for a particular category of service. For example, the number of inpatient hospital days covered by a State Medicaid Program might be limited to no more than thirty days.
Service Unit	A measure of the medical service rendered to a Medicaid recipient. The unit of measure of a service unit will vary with the type of claim. For example, the service unit for an inpatient hospital claim is days of stay while the service unit for a home health claim is visits.
Single State Agency	The State Medicaid Agency - The agency designated by the State plan for medical assistance to administer the State Medicaid Plan or to supervise the administration of the Plan. (See Handbook of Public Assistance Administration - Supplement D - Section 2100.)

Terms	Definition
Suspended	A term under to describe a claim that has entered into the automated claims processing system, but has not been adjudicated. Usually the inability to adjudicate a claim is caused by some type of claim error or claim data ommission.
Suspense File	A computer file into which are placed various transactions which cannot be processed completely usually because of the presence of an error condition(s).
Therapeutic Classification	A code assigned to a group of drugs that possess similar therapeutic qualities.
Third Party Liability	A condition whereby a person or an organization other than the recipient or the Single State Agency is responsible for all or some portion of the costs for health or medical services incurred by a Medicaid recipient (e.g., a health insurance company, a casualty insurance company or another person in the case of an accident, etc.).
Trend	A measure of the rate at which the magnitude of a particular item of data is changing. See Section 5.2 for a detailed explanation of how the trend value is calculated.

5.2 EXPLANATION OF TREND COMPUTATION

The TREND figure for a particular report item is a measure of the rate at which the magnitude of that report item is changing. Specifically, it is the percentage change in the average value of that report item for the last twelve month period. For example: if the trend value for "average cost per eligible recipient" is calculated as +.132 for a particular aid category, then the average cost per eligible recipient for that aid category has on the average increased 13.2% over the last year. The significance of the trend is not in the numerical value itself, but rather in its relative magnitude in comparison with other aid categories and in its indicated degree of upward or downward movement.

All trend computations used in the MARS Subsystem are based on the least squares method of fitting a trend line to a time series of twelve months. The trend increment derived by the method of least squares is normalized by expressing it as a percent of the arithmetic mean of the time series. The trend may not be accurately computed if there is less than 12 months of historical data.

The first step in the computation is the calculation of the weighted sums of the monthly data:

Current month's data	x 5.5 =	a_1
Second latest month's data	x 4.5 =	a_2
Third latest month's data	x 3.5 =	a_3
Fourth latest month's data	x 2.5 =	a_4
Fifth latest month's data	x 1.5 =	a_5
Sixth latest month's data	x Ø.5 =	a_6
WEIGHTED SUM $_A$	=	A

Seventh latest month's data	x .5 =	b_1
Eighth latest month's data	x 1.5 =	b_2
Ninth latest month's data	x 2.5 =	b_3
Tenth latest month's data	x 3.5 =	b_4
Eleventh latest month's data	x 4.5 =	b_5
Twelfth latest month's data	x 5.5 =	b_6
$WEIGHTED\ SUM_B$	=	B

The trend is now found as:

T = Trend = (A-B)/143(M) where M is the arithmetic mean of the 12 month's historical data.

It may be desired to use this trend in the projection of data to some future month. This is accomplished by first finding the twelve month average ending next month:

$$AVG_2 = (AVG_1) \times (1 + T),$$

Where:

AVG_2 = Twelve Month Average Ending Next Month

AVG_1 = Twelve Month Average Ending This Month

T = Trend

Since the quantities for the first 11 months of AVG_2 are already known, the quantity for the twelfth month is found:

$$Q_{12} = (AVG_2 \times 12) - Q_1 - Q_2 - Q_3 - \ldots - Q_{11},$$

When Q_1 thru Q_{12} are the quantities for each of the 12 months in the year ending next month. This procedure may be repeated to find data for future individual months.

This procedure may be extended to provide, in one calculation, the total projected fiscal year end quantity:

$$TOTAL = (AVG_1 \times 12)\ (1 + T)^N$$

Where:

TOTAL = Projected fiscal year end amount

N = Number of months between current month and fiscal year end.

Thus if the current month is February, there are four months left before the end of the year, and the projected fiscal year-end amount is:

$$TOTAL = (AVG_1 \times 12)\ (1+T)^4 = (AVG_1 \times 12)(1+T)(1+T)(1+T)(1+T)$$

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